HOUSE OF COMMONS SESSION 1998–99

WELSH AFFAIRS COMMITTEE

Fourth Report

HEALTH ISSUES IN WALES

Volume II

Minutes of Evidence and Appendices

Ordered by The House of Commons *to be printed*
29 June 1999

LONDON: THE STATIONERY OFFICE
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HC 343–II

The Welsh Affairs Committee is appointed under Standing Order No 152 to examine the expenditure, administration and policy of the Welsh Office, and associated public bodies.

The Committee consists of 11 members. It has a quorum of three. Unless the House otherwise orders, all members nominated to the Committee continue to be members of it for the remainder of the Parliament.

The Committee has power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any other committee appointed under the same Standing Order (and to the Committee of Public Accounts, Deregulation Committee, Environmental Audit Committee and European Scrutiny Committee) its evidence and any other documents relating to matters of common interest;

(d) to meet concurrently with any other such committee or the European Scrutiny Committee or any sub-committee thereof for the purposes of deliberating, taking evidence, or (in the case of any other such committee) considering draft reports.

The membership of the Committee since its nomination on 14 July 1997 has been as follows:

Mr Martyn Jones (Chairman)

Mr John Bercow (*discharged 22 June 1998)*
Mr Martin Caton
Mr Huw Edwards (*appointed 8 December 1997)*
Mr Paul Flynn (*discharged 8 December 1997)*
Mr Ieuan Wyn Jones (*discharged 20 April 1998)*
Ms Jackie Lawrence (*discharged 18 January 1999)*
Dr Julian Lewis (*appointed 22 June 1998*)
Mr Richard Livsey
Mr Elfyn Llwyd (*appointed 20 April 1998)*
Ms Julie Morgan
Mr Owen Paterson
Mr Chris Ruane (*appointed 18 January 1999)*
Mr Gareth Thomas
Mrs Betty Williams

Mr Martyn Jones was elected Chairman on 22 July 1997.

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Tuesday 23 March 1999

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1 Attachment to the NHS Confederation in Wales' submission
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MINUTES OF EVIDENCE

TAKEN BEFORE THE WELSH AFFAIRS COMMITTEE

TUESDAY 23 MARCH 1999

Members present:

Mr Martyn Jones, in the Chair

Mr Martin Caton	Ms Julie Morgan
Dr Julian Lewis	Mr Chris Ruane
Mr Richard Livsey	Mr Gareth Thomas

Memorandum submitted by the NHS Confederation in Wales is printed on page 43

Examination of Witnesses

MR IAN KELSALL, Chairman, MRS JAN WILLIAMS, Vice Chairman, MR PETER STANSBIE, Member of the Management Committee, MR RICHARD THOMAS, incoming Director (April 1999), MR PHIL DAVIES, Director, and MS MAGGIE AIKMAN, Director of Finance, NHS Confederation in Wales, examined.

Chairman

1. Good morning, ladies and gentlemen. Could you begin by introducing yourselves. Who is leading, first of all?

(*Mr Kelsall*) Thank you, Mr Chairman. I am Ian Kelsall, Chairman, of the East Glamorgan NHS Trust; I am Chairman of the NHS Confederation in Wales. On my far left is Mr Richard Thomas, currently the Chief Executive of Morriston Trust who will, from 1 April, become the new Director of the Confederation in Wales. On my immediate left is Peter Stansbie, Chief Executive of the Dyfed Powys Health Authority. On my immediate right is Mrs Jan Williams, Chief Executive of Iechyd Morgannwg, and also Vice Chairman of the NHS Confederation in Wales. Next to her is Ms Maggie Aikman, the Finance Director for Gwent Health. On the far end is Mr Phil Davies, who is currently Director of the Confederation in Wales.

2. Thank you very much. In your written memorandum you describe the "major structural changes" going on in the NHS and refer to the resulting "managerial turbulence". At the end of this month GP fundholding will end and Local Health Groups will be established; and at the same time contracting is being replaced by Long Term Agreements. Can you explain to us in simple terms how the new system will operate, and what difference it will make to patients?

(*Mr Kelsall*) As far as patients are concerned, there should not be too much difference. I think the changes are internal ones which will affect the organisation of the NHS in Wales and the structure rather than the service to patients. Certainly the abolition of the internal market and the introduction of the Local Health Groups (which I must say we do support as a Confederation and look forward to working with the LHGs when we begin operations) will be a pretty major structural change. At the same time we have had the reconfiguration of NHS Trusts, which has now been going on for some time. That too we do support; we do believe there was a need to restructure the Trusts, and we welcome the fact that there will be savings in terms of management costs; and also we believe there will be a more seamless service (as it is referred to within the NHS) instead of the divisions and the competition there have been in some Trusts in the past. One point we would like to make to you is we do hope after this that there will be a period of stability; there certainly has been turbulence. At the same time we have obviously had to run the NHS and look after patients (which we believe we have done and done satisfactorily) but it has been quite a big upheaval; and there has been a loss of morale on the part of some staff who still do not know where they are in terms of jobs. We do hope this will be it for a period of a few years.

3. Do you have any other concerns about the changes?

(*Mr Stansbie*) If you take together the Assembly for Wales, if you take the White Paper on Health, if you take the Green Paper on Health, if you take the reconfiguration of NHS Trusts we have seen coming out, then I think this is probably the biggest single set of changes we have seen since the 1974 reorganisation. I think what is happening is a very swift removal of the internal market. I think there is a lot of work to do, particularly for Local Health Groups. Local Health Groups are a big change from fundholding, which was individual practice-based, to groups of GPs covering populations in Wales which are the same as the local authorities. I think there is a very, very substantial process of change going on. Two things: the NHS in Wales will try to ensure that during that process of change patients are protected; and I think we all believe, following that bedding down, there will be better services and more equitable services. I think we are quite hopeful—there is turbulence and it would be nice to think it could have some consolidation of that before further change.

4. You have mentioned NHS Trust reconfiguration—are you satisfied with the Welsh Office's final plans for that?

(*Mr Kelsall*) Yes, Mr Chairman, I believe we are. I think to a very large extent it makes sense as far as we are all concerned. There has been some wait as far as Cardiff is concerned but that has now been resolved, hopefully. Otherwise, unless my colleagues disagree with me, yes, I think we are satisfied with it.

5. Do you share the Welsh Office's confidence that the reconfiguration will release £7 million for patient care?

[Chairman *Cont*]

(*Mr Kelsall*) Yes, I do.

6. In the short term do you think it may add to your costs, or has it added to your costs?

(*Mr Kelsall*) There have been some costs associated with reconfiguration, which have been funded by the Welsh Office. Certainly in the case of my own Trust (the Pontypridd and Rhondda Trust), we do see a pay-back within a period of 2-3 years (and I would say two years), and thereafter there will be a net benefit.

Mr Livsey

7. I want to go into the financial situation, which I think we all agree is pretty serious in the NHS in Wales. Before doing so, do you not think the set-up you have now got is excessively bureaucratic? Although you are losing GP fundholding, you have got Local Health Groups, you have got Trusts, you have got the Health Authorities as well, and now you have got the Assembly. That is a very bureaucratic structure to run the NHS in Wales. Do you not think it would be better to get rid of the Health Authorities perhaps and just have one?

(*Mr Kelsall*) I will have to be careful how I answer that, Mr Chairman, having representatives of the Health Authorities on either side of me. My assumption is, as the Local Health Groups grow in stature and take on the commissioning role, there will be a reduction in the role of the Health Authorities. I think that is necessarily so, otherwise there would be a bureaucracy. Whether my colleagues now want to shoot me or not, I do not know.

(*Mrs Williams*) In terms of the management of the NHS in Wales, it is a £2.5 billion service with 34 per cent. of the Welsh vote and therefore needs effective management, and we would argue it is the most complex public service to manage. You need to distinguish between the role there will be at national level for the Assembly setting national strategic direction and monitoring performance, and then looking at what Health Authorities will do, which is really at an intermediate tier, responsible for those things which are not appropriate to commission and neither could be commissioned effectively at Local Health Group level, which are unitary authority based as you know. There are some NHS services which simply could not commission at a unitary authority level because they are too small. I think Health Authorities will develop into a strategic shaping and leading role, managing the local health care system; and within that Health Authorities will be responsible for making sure that Local Health Groups deliver on things like improving primary care, commissioning services that are community-sensitive, and reshaping and remodelling hospital services. I think it is very important to distinguish the separate roles. We can see a role for Health Authorities at an intermediate tier, managing the local health care system under the direction and leadership of the Assembly.

8. The Assembly will have a strategic role and clearly, from what you have described, the Health Authorities also have a strategic role. Would it not be better if the Assembly was plugged into the an All Wales Health Authority; it could actually deliver the strategy of the Assembly, and the Trusts and the Local Health Groups could get on with the delivery of the service?

(*Mrs Williams*) You will be well aware of the social geography of Wales and the fact that health care needs differ markedly from one health care area to another. What Health Authorities need to do, working in an overall national framework, is to make sure the commissioning, primary care delivery is sensitive to the very, very different needs there are, for example in inner cities, in the valleys and in rural areas. I would suggest that that intermediate tier is the most effective to ensure those health care differences are provided for effectively.

9. Thank you for a good defence of the status quo—although I am not sure I entirely agree. Your memorandum refers to the growing financial deficit faced by many of the Trusts and Health Authorities in Wales, but makes very little of it. The latest figures from the Welsh Office show a cumulative deficit of some £54.1 million. How seriously do you take the requirement to break-even? Is running a deficit perhaps seen as a good way to get extra money from the Government for much needed services? I think we ought to say at this point the Secretary of State has been quite hawkish about this, and seems to indicate the loans which have been sustaining the Health Services for some time now may possibly be no longer there.

(*Mr Kelsall*) If I could begin, Chairman, to answer that question. As Chairman of the Trust can I say, as far as I am concerned, there has always been a determination if at all possible to meet targets; there certainly has been no desire to run into deficit. My own personal belief is that once you get into a deficit situation it is extremely difficult to get out of. I do not believe any Trust or Health Authority has deliberately run into a deficit situation so as to be able to screw more money out of the system. I think one has to look at the background of what has been happening and is happening in Wales as far as the Health Service is concerned to understand and appreciate why there are deficits. First of all, the health needs of Wales are so much higher than those of England in almost every respect. The demands on health services is considerably higher than is the case in England. In the second instance there has, over a period of years, been quite serious under-funding of the NHS in Wales. For example, some of the pay awards have not been fully funded and the Trusts and Health Authorities have been left to find the balance themselves. Apart from that, I think there are structural problems within the Health Service, within some Trusts. Some Trusts are perhaps not structured in terms of the services they operate, in the way they would like to operate. For example, ideally in some cases they may wish to close particular hospitals which are a drain on their finances; but closing a Health Service facility of any kind is extremely difficult as I think we all know. I think there is a very complex background. I would also say that, over a period of at least ten years, there has been a very great effort on the part of the Health Service in Wales to become more and more efficient. I have been in the Health Service now for six years and every year we have been faced with cost improvement programmes, some of which have been quite unrealistic in my

[**Mr Livsey** *Cont*]
experience. I think we have now got to the point where there are not any more savings, that housekeeping will not yield any more, so I think the situation is potentially very difficult.

10. I would particularly like to ask Mr Stansbie, I know Dyfed Powys is carrying one of the biggest deficits, and I think I am right in saying it is round about £15 million or thereabouts. Mr Stansbie, given the huge area you cover and the morality of it, and perhaps the funding formula is not adequately compensating for the extreme morality, and we have huge administrative problems as well because of the size of the area, do you think that is inequitable at the moment, that it could be better?

(*Mr Stansbie*) I think there are two problems. One is that the Health Service started on a funding basis which actually encouraged the building of hospitals—if you built hospitals then revenue followed. It was not until the late 1970s that changed and we moved to a capitation formula, but that really did not take full effect until the 1980s. The consequence of that for all of Wales (and then I will come on to Dyfed Powys) is you had a system set up with one form of funding that moved into another form of funding. Particularly in the rural areas (but not only the rural areas, in some cities and some of the big parts of the country—and Wales is a big area with a small population) you do have an effect that the capitation formula does not fund you for the resources you are having to spend particularly in the rural areas, but not only in the rural areas. The capitation formula is complicated; it is not simply the number of people; it also balances deprivation, it balances a whole range of factors. When we started as a Health Authority we said this needed to be looked at, but we were quite clear in our original strategy document that simply changing the capitation formula would not resolve the issues for rural areas—because the nature of the formula means you would not get the balance on that. I think our view is the capitation formula (and it may change but the change is fairly marginal) is fair and equitable; but on top of that you do need to recognise a range of places, particularly in an area like Dyfed Powys—half of Wales, a small population, four general hospitals, 22 community hospitals—that there has to be some recognition of the cost of providing this, or you have to restructure the Service. I think this is going to be one of the challenges for the Assembly. If the budget is fixed within the Welsh block or separate from the Welsh block, if we are to manage within that resource there will have to be structural change. It is a complex question. As you know well, we have spent three years trying to find a solution that allows us and our Trusts—because it is not the Health Authority or the Trusts that hold the deficits in Wales, it is the NHS system; if we do not get the money the Trust cannot; if the Trusts overspend we have a problem. We are looking, and all our colleagues are looking, at how we can move out of year-on-year small cost improvements into real structural change. That is a real challenge, particularly for the public who, as we have seen, really fiercely guard their local hospitals, whether they are community hospitals or general hospitals. I think that is a challenge for us. It is a very complex issue. If you go back to the figures that Mrs Williams was quoting, this is a huge business, the biggest single part of the block in Wales that employs a huge number of people and is fiercely loved by the population; how we manage that is a real challenge to us. I do not think there is one single simple solution; if there was I think we would have found it. I think we have to make a whole range of changes to make sure we can balance the books. Certainly nobody in NHS Wales believes that simply having a deficit will mean you can get more recurring resources. That has never happened in the past and we do not think it will happen in the future.

11. Are you saying it is a straight choice between restructuring or changing the formula? Is that the situation? Given the pain that Trusts are having to suffer—because clearly there is a deficit which has to be found and the Trusts are being asked to cough up £4 million or £5 million, that is a huge amount of cutback in service provision—certainly it is a very rough round for local communities and the Health Service in those areas.

(*Mr Stansbie*) Yes, it is. One of the issues the Confederation has always said (and we are here as a Confederation of course) is if the overall level of funding in the NHS remains reasonably the same, however you divide the cake (because that is all the formula does, it does not provide more funding but simply divides the funding we get) if that does not substantially increase then there are going to be difficult choices. It is something we cannot avoid.

(*Mr Livsey*) I think what the Chairman said and what you have said is you cannot go on simply making 2 per cent. a year, some of which is unrealistic anyway, but you are faced with choices that are very difficult, particularly for local populations.

(*Mr Stansbie*) Our belief is that in doing that we can improve the quality and the diversity of service, but it does not feel like that to the local community.

Mr Caton

12. You mentioned the three years you spent looking at the funding formula, are you disappointed the changes I believe you came up with have not been put into operation?

(*Mr Stansbie*) Our Authority wanted that looked at. We recognise at the end of the day, as we were saying in Wales, "Perhaps we ought to move to the English formula", but England were saying, "Well, actually, we want to review the formula". I think our view was it was sensible to pause at that point and do some more work on the formula. I think in terms of simply changing the capitation formula, which has been done a number of times in England and Wales, you do not get big changes of funding for any area. Its cumulative effect is substantial. For us, for example, over the last five years the change has been something like a loss of £8 million. What we have to look at is, given the size of the cake is fixed and that all the formula does is change the way that cake is divided, how can we use that cake sensibly to improve quality, to deliver the year-on-year increases in emergency admissions, in elective admissions, and that is a challenge that NHS Wales and the Assembly face for the next few years whatever happens to the formula.

[**Mr Caton** *Cont*]

13. I take your point but some people have put it to me that, at the moment, the formula does not give enough emphasis to deprivation and poverty where there is a clear health link. Do you think that is fair?

(*Mr Stansbie*) Mrs Williams should come in on deprivation and poverty. I think there is a balance in all these things. If you put more in for deprivation and poverty it is probable some of the rural areas (where deprivation and poverty are very difficult to measure although it may be there) will lose out. I do not think there is a right or wrong in this formula, I have to be clear on that. What we are all striving to do is get to the best cutting of the cake so the whole population of Wales gets a reasonable service. What I think is clear is the whole cake is stretched and, therefore, difficult choices are faced.

(*Mrs Williams*) I think the Morgannwg Health Authority stance has been that the formula does not provide for social deprivation and poverty indicators sufficiently. For our Health Authority, for example, we have managed to maintain a balanced position, but the Health Authority has significant areas of social deprivation (particularly in Neath, Port Talbot and in the inner city areas of Swansea and the valleys in Bridgend). We have remarkable inequities of access to service. For example, the people in Neath/Port Talbot do not get sufficient access to cardiac services; the people of Bridgend do not get sufficient access to renal services; the people of Swansea do not get sufficient access to mental health services. The Health Authority has not been able to move towards putting these inequities right, because we have used the allocation we have simply to maintain existing services. There is an issue for my Health Authority in terms of social deprivation. As Mr Stansbie has said, there are balances to be struck between rurality issues, social deprivation and poverty indicators. I think the message is overall, unless there is a significant increase in the resource made available to NHS Wales, very hard choices have to be made about what the population can expect for primary care, what they can expect from local general hospitals and what they have to go further afield for. That is the debate the Confederation and the Service in Wales wants to engage the National Assembly in.

Mr Thomas

14. It is quite obvious there is a multiplicity of challenges and problems which face the NHS in Wales. Would you agree with that?

(*Mr Kelsall*) Yes.

15. Would you agree also that what is implicit in all of this is there is a need for some leadership in order to make some of these tough decisions about restructuring and strategy?

(*Mr Kelsall*) Yes, I do agree with that.

16. How do you think we could get that leadership? One is looking to the Assembly obviously?

(*Mr Kelsall*) I think, Chairman, that is right. As far as the Assembly is concerned, we are certainly hoping it will bring a more strategic direction to the Health Service. I would like to refer to the review that has taken place—

17. Before you do, could I just bring in one very quick point you might want to consider in your answer—it is something I am aware of and I am sure my colleagues are, which is to do with the fact we do not have an NHS Executive in Wales. This might be a crude way of putting it, but basically the civil servants run the Health Service and also advise the Ministers, and there are problems about accountability for that reason. Perhaps you could deal with that when you answer.

(*Mr Thomas*) You probably know that the Welsh Office Health Department is being restructured following the Hart Report, so that there is more direct management of the Health Service at all its levels. That restructuring is currently under process. The new Director of NHS Wales has just been appointed. You may have seen advertisements in the national press last week for key players. The Confederation agreed that this will bring more direction and strategic direction and planning to the Service in Wales.

18. Why?

(*Mr Thomas*) Because over recent years there has been a lack of that direction and policy.

19. Why do you think that has been?

(*Mr Thomas*) I think there is a variety of reasons. I think the internal market set up under the previous government encouraged Trusts to be competitive. I think planning went out of the window at that stage. I think services were developed outside a strategic framework. I think the development of services in some parts of Wales is perhaps not affordable.

20. You would agree there is a real need for some leadership?

(*Mr Thomas*) Yes. I think we would want to see how the new NHS directorate, which will work with the Assembly, performs. The Health Service in Wales should work closely with the Director in that respect. It is badly needed; the Hart Report recommended it; it has been implemented; and we are all looking and watching with great interest to see how that develops.

Chairman

21. Before we leave financial deficit, could I ask Mr Thomas what the present position is at Morriston?

(*Mr Thomas*) The present position at Morriston is that we are projecting an end of year outturn of approximately £2 million deficit. That is within the figure we have agreed with the Welsh Office and the Health Authority. When the present Trust Board, under the chairmanship of Sir William Asher, was established twelve and a half years ago it was faced with a deficit in the region of £6 million. The financial outturn at the end of 1998, 12 months ago, was that the £6 million deficit was down to 1.7 million, but that did not include the recurring loan. We have agreed with the Welsh Office a recovery plan, which is still being reviewed. The Trust commissioned an expert external advisory group, led by Professor Brian Edwards of Sheffield University, who produced a report which said that perhaps the affairs of Morriston Hospital were not as bad as perhaps everybody first thought. It is a very specialised hospital; it runs a wide range of tertiary/ regional services—because of their nature they are more

[**Chairman** *Cont*]
expensive than in a normal general hospital. He said that the hospital is not overstaff; it is no longer inefficient, but there is still room for efficiencies. In the Trust's wind-up report, as it comes to an end in five or six days' time, we are proud to be able to say we are handing over to the new Trust a firm platform in which they will be able to achieve fully the recovery plan. We are reasonably confident that will happen now. It is a slight disappointment that the present Trust will not be there to see it off. As has been said earlier, we support reconfiguration in Swansea; it is the right thing to do and I think the new Trust will be in a strong position to take responsibility.

Mr Ruane

22. In your report you describe how emergency admissions have increased in summer as well as winter. Why do you think that is?

(*Mr Kelsall*) Chairman, I wish we knew the answer to that. I do not think we do. Colleagues may be able to help you further.

23. Have you commissioned any research on it?

(*Mr Stansbie*) Not in Wales I do not think.

24. Have you asked any questions of it?

(*Mrs Williams*) Obviously each Health Authority area and Trust looks at this very closely. What we can say, again there are a multiplicity of reasons. If you take the high level of sickness that Welsh people have, the higher admission rate to hospital across the principality, I think there are issues associated there with people living alone who become very vulnerable; and there are issues about social care pressures. The NHS in Wales is in financial difficulties as are our Social Services colleagues. Unitary Authorities do face Social Services budget cuts each year. We operate a Health and Social Care Service and that is symbiotic, resource constraints on one have an impact on the other. We do find people admitted inappropriately to hospital because the social care package is not there, and we do find discharging people from hospital is a problem as well. We do look within Health Authority areas to see what the reasons behind emergency admission increases are. We do have variations across the five Health Authority areas. Whilst we have had a 13 per cent. increase overall in the last three years it differs markedly from one area to another. It is something we monitor very closely; we work very closely with Trusts and Social Service colleagues. There is an issue, but it should not be either funding for the NHS or funding for social care because we are part of the same care environment and need to work together.

25. You are saying there is great cooperation between Social Services and Health Authorities, but in my experience they say, "We shouldn't be paying for that because this woman is dying and she should be put in a rest home".

(*Mrs Williams*) Since the five Health Authorities came into being in 1996 we have spent a long time building an effective working relationship with unitary authorities and with the Welsh Local Government Association, which is the national body. I would say all five Health Authorities have made significant progress in 1998, and the arrangements for managing the winter pressures this year have shown a marked improvement. Of course, it was helped by the fact 20 per cent. of the winter pressures money allocated to the NHS was given over to Social Services and that is an issue for us; in that it was non-recurring, and these pressures do not end at the end of March, they recur into a new year. That will give us an ongoing problem if that money is not included in the baseline allocation. I think it is fair to say that we are building up a stronger and more effective relationship between the Health Service and the Local Government in Wales.

26. If you are building them up, at one point were they weaker and more inefficient?

(*Mrs Williams*) I think it is fair to say before the five Health Authorities came into being there were issues about the working relationship and working together between Health and Social Care. When each organisation is under financial constraints, to the extent that we are, in some ways it is natural for the NHS to say, "It's a Social Care issue", and for Social Care to say, "It's NHS". I think we are moving beyond that and we are working jointly. We do welcome joint guidance coming out from the Welsh Office, joint Health and Social Care priorities guidance for next year, because that will help Health and Social Care organisations plan and work better together.

Ms Morgan

27. Do you think there is a bit of artificial division between Social Services and Health, and do you think there will be any advantage if in the future there was some way of bringing them administratively closer together?

(*Mrs Williams*) We are looking forward to the duty of partnership that will be enacted shortly between Health Authorities and Social Services. There are initiatives under way to enable us to bring services together and I think all this will be of benefit. Yes, we do have to look at the services provided by the NHS, the services provided by Social Services, and how can we pull together better. That will be our role as Health Authorities in leading the health improvement programmes. We are hoping the Social Services and other unitary authority departments will participate fully in the development of the health improvement programme.

28. I have always felt they should come closer together but one of the issues has been the fact that the NHS has been free at the point of delivery. I know there is debate about how we are going to go on funding that. Local people have always had to pay for their care in local authority homes. I wonder if you have any comments on that because that is one of the things which has influenced my thinking on it.

(*Mr Stansbie*) I think there are some interesting things we ought to look at comparatively. Northern Ireland has had an integrated health and social care model for some time. There are some experiments in Somerset to bring Trusts and Social Services together. It is worth studying those, because one of the challenges I always throw out flippantly is, if anybody can define the difference between a Health bath and a Social bath they get a prize. It is very difficult to make those distinctions. What I think is

[**Ms Morgan** *Cont*]
clear, if you look at Northern Ireland and see what happened with the experiments there are still issues about where the boundaries lie. Because there is a difference between health care and people's continuing living, particularly the elderly but also people with special needs, what we have to do (and in Wales we are now well poised to do it) is to make sure we use whatever powers we have (because we do not want more structural change) to make sure we are working with local authorities. I think there is a national challenge, particularly in care of the elderly, with commissioning and with some challenges taking place in the courts. I think the reality on the ground for the person who needs the care is the issue that we ought to be able to get together and ensure that person gets the appropriate care quickly, efficiently and in a caring way. That is a challenge for us and for local authorities. I believe Health Authorities and Local Authorities in Wales are now well placed to do that, with health improvement programmes with Local Health Groups and with health alliances (Better Health:Better Wales) which lead from local authorities. I think there are some real opportunities, but we have to keep studying it; it is not a simple issue but one that is a real challenge for the people we care for.

Mr Ruane

29. You argue that additional funds to meet winter pressures, though welcome, are insufficient and that funds are needed on a recurring basis. How much more money are you arguing for?

(*Mr Kelsall*) I think there is a general point, first of all, that the money arrived a bit late for us. I think it was November or December before we had the allocation, and then to have to try to recruit doctors and nurses to deal with it is a bit late for winter pressures. Secondly, if you are recruiting staff you obviously do not want to recruit staff and kick them out six months later. Therefore, there is a need for that money to be recurring so you can provide that service permanently. There is every indication, as far as we can see, the winter pressures and the emergency admissions are going to continue, and possibly increase.

30. Is this an argument for increasing the base line for the NHS funding?

(*Mr Kelsall*) Not really. I think it is basically saying this is an additional pressure which is now going to be with us permanently which has to be recognised and funding allowed for.

31. You say that the "late release" of the £11.5 million you were given this winter meant that its use was constrained. Did you get the money later than expected, or do you simply mean you were unable to plan ahead?

(*Mrs Williams*) I think the first thing was we were not aware we would have an additional allocation until late on. Given the constraints under which we work and the tight management resource we have to work within, it was not possible for us to spend time planning, particularly with Social Services colleagues, not knowing whether the results of that planning would ever come to fruition, because we did not know we were going to get extra money. That is the first thing. We would want the possibility of extra money flagged up early on in the financial year, so we could put sensible planning mechanisms in place. I think both ourselves and Social Services would feel we had sub- optimal schemes in some parts because it was so late, and in fact it really gave us four months funding and, as Mr Kelsall has said, you do not attract scarce professional staff to come and work on a four-month basis. What we are asking for is earlier notification and a recurring allocation.

Mr Livsey

32. One short question but a very important one, it is about ambulance service and it fits into this question about emergency admissions. There has been a reconfiguration of ambulance services and there is now an All Wales one, as you are well aware. We are faced with a very difficult situation in Powys where we do not have a 24 hour ambulance service. I recommend no-one to have a car accident in Powys after 12 midnight and before 7 am in the morning. This is a very, very serious situation. We do not have emergency cover during that time. Have you as a Confederation made representations to the All Wales Ambulance Trust about this, because it is causing immense concern in the area I represent?

(*Mr Stansbie*) I think there are two issues. Because there is 24 hour cover from the ambulances the issue is in the rural areas, and Powys is particularly rural—it is a huge area and about a quarter of Wales. There are real issues for how you provide access on 24 hour coverage in the timescales that we need. I do not think the Confederation *per se* has pursued it with the Ambulance Service. We have regular meetings; we had them with the previous Ambulance Trusts; we have them with the new Ambulance Trust and it is difficult. I think one of the issues we have to look at in Wales is how can we provide a really effective ambulance service for a really huge area with very sparse populations. What you have to do is try and balance the resources you have with the needs.

33. There is an eight minute response time and that is not being met at all. I know of a case where somebody died, where you are in danger of getting sued by people; and we all know the problems of litigation coming into the Health Service at the moment. You have left the situation extremely exposed. I would like to know whether your contract, with the Welsh Ambulance Service, insists on an eight minute response time in Powys, or not?

(*Mr Stansbie*) The response times are national targets and not Health Authority targets. My view is that the Ambulance Service, within the resources we can find and it can find, cannot deliver that in rural areas. I know they are working very hard to try and find ways around that. Simply to say today, "We can resolve it", would be untrue. I think there are big issues, not just in Dyfed Powys but in all the rural areas of Wales, north Wales as well, and we have to look at those. There are similar issues in the rural areas in England and Scotland as well, because the response times are national response times but do not take any account of areas such as ours. I know the Ambulance Trust is working very hard to look at ways it can deal with it, not only in Powys but in North Pembrokeshire, in a whole range of areas,

[**Mr Livsey** *Cont*]
Ceredigion, all of which have similar problems. I am not going to sit here and say we or the Ambulance Services have a resolution to it at the moment because we do not; but we are working very hard with the Ambulance Trust to try and improve the services. We certainly do not want people dying. With the new All Wales Ambulance Trust we are looking at innovative ways in which we can deal with this rural area, but we will not do it overnight.

Mr Livsey:An honest answer, but at least we have identified the problem.

Ms Morgan

34. Could I ask you about waiting lists and waiting times. You argue for "a fresh look at the approach to people waiting for treatment", emphasising waiting times instead of waiting lists and taking into account clinical priorities. Obviously that sounds very sensible, so what is stopping you from doing that?

(*Mrs Williams*) Clearly we recognise the target the Government has set in terms of the reduction on waiting lists, and we are obliged as a Service to look towards meeting the target reduction share of Wales. Our issue is that where an individual is on a waiting list, that individual really does not mind how many other people are on the list; what that individual is concerned about is how long he or she is waiting, and particularly if he/she has a condition that is classed as urgent, a clinical priority, that they get seen quicker than a routine referral. What we very much hope the Assembly will do is to be more flexible, recognising that we do have to meet the Government's commitment in terms of waiting list reduction. I think we would say, yes, we want to work within that. We would like a more sophisticated look at what should maximum waiting times be for general outpatients, and is it possible within that to look at clinical priorities, like cataracts for example, and say that they should have a shorter waiting time or no waiting time at all, given the improvements in quality of life that can result from immediate surgery in cataracts. We are very much hoping we can move into this whole waiting time debate.

35. Do you feel the Government is a bit inflexible?

(*Mrs Williams*) We understand the wish to bring the numbers of people waiting down, but we think it is not the most appropriate measure against which to judge NHS performance. We think responsiveness of waiting times for individuals would, in our view, be a more appropriate measure.

Dr Lewis

36. Are you saying, in fact, that waiting times are actually increasing as a result of excessive focusing on waiting lists? Do you believe that there is some truth in the criticism that one of the effects of focusing excessively on waiting lists is that people then find themselves waiting to get onto waiting lists?

(*Mrs Williams*) We are certainly experiencing an increase in waiting times, particularly in outpatients; because, as you know, the Government's target is focused on day cases and inpatients, and that is where a lot of resource has had to be targeted this year. The Service is building up a considerable problem for itself on outpatients, particularly from next year onwards, which we have made known to the Welsh Office because we have considerable concerns about that. In terms of people waiting to get on to waiting lists, that is a very complex issue and depends on the way GPs refer into the system. There is no doubt that if GPs see a long waiting list they hold back referrals; if they see waiting lists and times coming down then they increase the referral list and that is the consequence.

Ms Morgan

37. You argue that the £18 million you were given to reduce waiting lists needs to be recurring in order to keep the reduction down. Was that money not intended as a way of getting the lists down in one go?

(*Mr Stansbie*) I think there is a problem with this. As Mrs Williams has said, one of the effects this year of a right concentration on the number of inpatient lists is that outpatient lists have tended to increase, because we have concentrated on dealing with people already on the inpatient lists. The result is that for next year across Wales you have to do even more inpatient cases to deal with the people coming through from the outpatients. Roughly a third of people appearing on outpatients lists have to subsequently have an inpatient procedure. In fact, the money not only has to continue as a recurring sum but has to increase year-on-year if you are to further reduce the waiting lists, and that is a problem to us. I think the other issue about lists rather than times is that we have already mentioned the growth in emergency medical admissions; by doing more work on elective inpatients lists again we are increasing workload. The consequence of that in a position where there are already financial deficits is that it can make them worse. There is a real problem, and it is one of the other reasons we are saying the really effective concentration should be on clinical need, on time; because that is the way patients actually measure the effectiveness of the system; they do not measure other people on the list, they simply want to know how long it is going to take them to see the GP, see the consultant and then have the operation if they need one. Without doubt, that waiting list funding, if the list is to continue on a downward trend, has to not only continue but it has to increase; and that is because more and more people are being referred. I think there is an issue here that we do have a problem, as politicians and as the NHS, with the media. We do try to concentrate on times and the headline figures are always the number on the lists. It does seem to me that the NHS and the politicians have a job of explaining to the people in real terms what the situation is. I think that is a duty we both have. This is not easy, this is very complicated. The NHS year-on-year since 1948 has treated more people, has treated more elective cases and the waiting lists and waiting times have gone up. There is an issue that we have to try and join together to get a better service in terms of quality.

(*Ms Aikman*) It is quite important to have this money on a recurring basis. One of the reasons for that is because we would be able to treat more patients if we had that money on a recurring basis. The reason is we tend to have to use non-recurring

[**Ms Morgan** *Cont*]
money to pay for overtime rates for patients to be treated—we have to pay for people to work on Saturdays and we have to pay for people to work extra sessions; we even have to put our patients into private facilities. If we knew this money was coming in advance we would be able to produce the capacity and probably treat up to 50 per cent. more patients than there are at the moment with the same amount of money.

(*Mr Thomas*) You referred to the negativity of all of this—waiting times are very important and the Confederation are as concerned as everyone else about that. I think the figure that never appears is of the totality of patients being treated in the NHS: 90 per cent. of them are seen within a month of referral. We tend to forget about emergencies and the day-to-day admissions to hospitals. It is a figure I have never seen published, but it gives you some indication of how effective the NHS in Wales is, and the NHS in England.

38. That was going to lead on to my next question. Should people not be treated when they need the treatment, rather than be on any waiting lists? There seems to be such a huge effort about the waiting lists, and obviously that is the sort of situation we would like to reach.

(*Mr Stansbie*) There is an issue about waiting lists. They were a way of rationing the NHS since 1948. There is another issue, which is that clinicians tell us that in some cases you do sometimes need to wait, and there is an issue for clinical care. The issue is getting the balance right as we were saying. If you take cataracts, for example, one of the things we would like to see is that people at the point when the cataract is "ripe" and ready for operation do not have to wait. Cataracts are very easily treated, they are very debilitating if you have them and if you can cure them there is a great health benefit. We are saying we ought to try to get more sophisticated (and we know it is difficult with the media) in the way we look at people waiting. Simply having no wait at all would not be satisfactory in some cases.

(*Mrs Williams*) One point related to that refers to what we talked about earlier, in terms of looking at new ways of providing services and restructuring in that sense. One of the things that the service is looking at and will want the Assembly to take on board is this question of the management of emergency work and the management of elective work and separating the two. For instance, in Morriston, elective orthopaedics have to take second place to emergency trauma. One of the things we will be looking for in the coming together of Swansea and Morriston is separating the emergency provision from elective provision. It will be a new way of thinking in terms of managing elective care. That is certainly something that the NHS needs to develop if we are to maintain a proper elective service into the next century.

Mr Caton

39. Your memorandum raises the problem of recruiting general practitioners particularly in the valleys and in rural Wales and you point out that 20 per cent of GPs are due to retire in the next five years. That is a general problem. What do you think needs to be done about that? I am also concerned about those most disadvantaged and deprived communities and I wonder if there we should not be moving to salaried GP services as part of a high quality primary health care service for those disadvantaged communities.

(*Mrs Williams*) I think the question of GP recruitment is one that exercises health authorities and we recognise that, again, there are a multiplicity of reasons why we are having difficulties. If we think of Wales for example, in the last five years the number of GPs in training has gone down from 133 to 66. That is nearly a 50 per cent reduction. Even with the problems that junior hospital doctors have, it is still more attractive for graduates to go into the hospital medical profession than to go into general practice. So we are looking to see what we can do as health authorities to make the vocational training scheme for GPs more attractive. Mr Stansbie and I are part of a group that meets with GP trainers regularly and one of the things we are hoping to do, for example, is to increase the vocational training scheme to three years because they feel two years post-graduate training is insufficient for the requirements of the modern general practice. We are very concerned at single-handed practices within Wales and we will be looking at salaried GPs, the use of non-principal GPs (these are people who are not partners but who are qualified and who want to get back into practice) and we are looking at part-time working. There are a lot of women doctors in Wales who are not working and we will be wanting local health groups to really major on this mapping of the primary care provision across their area and really drive forward changes that are needed, particularly for the inner city and valley areas and rural communities. So it is something that is very much on our agenda.

40. Thank you. I understand that research amongst medical students shows that they are very attracted to a salaried approach for the future rather than the traditional entrepreneurial approach.

(*Mrs Williams*) We are certain it is going to grow in popularity and we all have schemes that we could offer to GPs in that respect.

Dr Lewis

41. On pages 8 and 9 of your briefing you list nine points about the significant cost pressures which the NHS faces during the coming year. The first two of those are where you say that the impact of wage awards will be about £80 million and other workforce changes such as in junior doctors' hours will add another £7 to £10 million to the bill. How much of this are you expecting to have to meet out of existing resources and how much do you expect the Government to meet?

(*Mr Thomas*) The short answer to that is we would expect the Government to fund the whole of those pay increases. The allocation for Wales for the coming year has not been finalised but the indication to date is that the pay awards generally are only to be part-funded. The Confederation has made representations to the Welsh Office in this respect and we do know that they are taking that advice on board before they finalise the allocation for the current

[**Dr Lewis** *Cont*]
year. You have the figures there. You have to remember that the pay bill in a typical NHS trust represents about 70 to 75 per cent of its expenditure and one of the reasons why the NHS is facing the financial problems it is is because year on year pay and inflation has not been fully funded. That is why this year we have been very clear to the Welsh Office about the importance of fully funding pay awards. We welcome the Government's recent paper on reforming pay. I think there is a great deal of mileage to reform the quite antiquated Whitley pay system which is currently in the NHS and we would be working together with the Welsh Office and Government giving them advice about how best to take that forward. We think that is an important step and we have not fully addressed the funding pressures but there has to be a better way of handling pay within the Health Service in the new millennium.

Mr Caton

42. I think this is implicit in what Mr Thomas has just said but following on from what Mr Kelsall said earlier that there is no fat to cut, and that there are not the efficiency savings that there perhaps were in earlier years, if the pay award is only part-funded will that result in a reduction of service?

(*Mr Kelsall*) Yes.

(*Mrs Williams*) Yes and loss of jobs of course.

Mr Ruane

43. I have a constituency in North Wales and one of the main issues with the health authority up there is cross-border services and we have received evidence from North Wales Health Authority on the funding of cross-border services. They express concern that the contracting by the Specialised Health Services Commission for Wales may duplicate existing contractual arrangements made for North Wales patients by the health authority. Can you explain this to us?

(*Mrs Williams*) I will answer your question in respect of the Specialised Health Services Commission, if I may, because I have been very involved with my colleagues from North Wales and the Chief Executive there Brian Jones, in developing a Specialised Health Services Commission for Wales, to which all the five health authorities will contribute and which will take over the responsibility for commissioning an agreed range of services. It will not duplicate what health authorities themselves do so we will make certain that it complements rather than duplicates, but we came to a decision in early 1998 that we needed to set up such a Commission because of the practical experience we have had over the last three years of commissioning services like cardiac and forensic psychiatry. We recognise that these services are so specialised and high cost and low volume or subject to increasing technological change and therefore increasing in cost that we needed to manage them at an all-Wales level. We looked around for other models that were already in operation in England and Scotland and we went to see the Scottish model which we were impressed with. That is very much the basis on which we have gone forward in Wales and the Commission will be operational from 1 April this year. I know that the director of that Commission, Dr Gillian Todd, has met with North Wales colleagues and has agreed the range of services that the Commission will in time take over from North Wales Health Authority. That is the case for the other health authorities as well. So I would suggest that any concerns that North Wales has expressed will be unfounded in practice and it is certainly the intent of the five health authorities to work together on this very specialised ranges of services.

Chairman

44. It is interesting what you are saying, Mrs Williams, but North Wales Health Authority tell us that as a result of this change from commissioning for a resident-based population to a practice based population with local health groups there are 7,000 people who have services purchased by English health authorities and conversely North Wales will purchase for about nearly the same number of English patients. Can you explain this to us and is it the same all the way along the border of England and Wales?

(*Ms Aikman*) The answer to that is that we will be buying some services for English patients if they belong to doctors in Wales and it is the same along all the borders. It is obviously the reverse in that England will be buying for Welsh patients who are the patients of doctors who work in England.

45. Does it matter?

(*Ms Aikman*) It can matter because it depends on the amount of money that transfers as a result of that. The Welsh preference was that we had a capitation amount moving. The debate that the Welsh Office had with the executive did not come up with that solution. They came up with the solution that we would have an amount of money transferred related to the service which had been provided for those patients in that year. I am not quite sure about North Wales figures but certainly in Gwent we have received about half of what we would have received under a capitation basis. So if the flow is inwards, yes, we could be suffering financially.

Chairman: I think we are in North Wales, speaking as a North Wales member. It may be worth looking at that in future. Mr Thomas?

Mr Thomas

46. Coming back to Mrs Williams on the issue of the Specialised Health Services Commission, how will that be financed? Am I right in saying it will be financed by means of top slicing from that part of the Welsh block which has been designated as health spending?

(*Mrs Williams*) The health authorities have set it up and put their discretionary allocation into the Commission's budget. At the moment the funding for specialised services is within each of the five health authorities' allocations and until such time or if the Assembly chooses to change that arrangement that is where it will continue to sit. So we will delegate

[**Mr Thomas** *Cont*]
responsibility on behalf of the five of us to the Commission and its team to actually commission on our behalf.

47. Let us explore that a bit further if we may. Does it actually mean that the North Wales Health Authority will have to pay for certain specialised services which may be based in South Wales?

(*Mrs Williams*) North Wales, as you know, makes very little use of the South Wales specialist services. The large majority are in England and it does not mean that the North Wales Health Authority would have to change its commissioning pattern. The Specialist Health Services Commission will take over responsibility for the arrangements that North Wales has and will manage those on behalf of North Wales Health Authority.

48. So in fact this Commission will be purchasing services from England?

(*Mrs Williams*) Yes as well as from Wales.

(*Mr Stansbie*) As it will almost certainly in Dyfed Powys as well because the north of Powys particularly looks to England—Birmingham and Shropshire—for some specialised services. The important thing about the Commission is to try and ensure there is as much equity of access as we can get across Wales. Whether the services are purchased from England or Wales the issue is making sure people can get access to the services. I do not know when North Wales provided the evidence but it may well have been prior to the discussions between the health authority and Dr Todd about which services are going to be bought. As the five health authorities we were very clear this was not going to be a big bang, we would take it gently, but there is no intention at all that North Wales would pay twice for services nor Dyfed Powys.

49. There was a time when they were in relation to the cardiac service in Morriston. Am I right about that? That led to the extraordinarily anomalous situation whereby North Wales Health Authority was actually paying for services that there was no way it could use given the geographical distance.

(*Mrs Williams*) Perhaps I could answer that because the cardiac centre was set up using what is called ring-fenced monies for the first three years and it is true that each health authority made its capitation share contribution to the service so, yes, there was an element of money that North Wales put in and clearly it is very difficult for North Wales residents to access the Morriston service. We were looking to see, one, could it be done and then, two, could we buy out the North Wales share in the south. Of course, these things do work in reverse because there is a forensic psychiatry unit opened in North Wales. We have all paid into that as South Wales health authorities and it is very difficult for us to get access to that unit. So it is a function of the all-Wales Funding formula and the ring-fenced arrangements which I would not say any of us are happy with but that is the mechanism within which we work.

50. I am grateful for that response. I am intrigued that there is nobody from North Wales on your rather impressive panel today.

(*Mrs Williams*) We understood it was not possible for North Wales colleagues to join us.

Chairman

51. There was supposed to be a representative from North Wales.

(*Mrs Williams*) Yes, we understood that.

Mr Livsey

52. The North Wales Health Authority also expressed concern about the potential loss of financial and planning control with the change in process from extra contractual referrals to out of area treatments. Please explain this? Do you share their concern?

(*Ms Aikman*) Yes, I think we do share the concern because at the moment we are not quite sure what the mechanism is going to be for the monitoring of out of area treatments. Up until now we have had control over a certain number of what were extra-contractual referrals in as much as we had to give approval for that activity to take place. That is no longer going to happen with the out of area treatments. We are also not yet sure about the information system which is going to record those out of area treatments and how that is going to get back to the health authorities, in particular those across the border into England. We are at the moment having discussions with a clearing-house in England to see whether or not we can get information so at least we can monitor in year and find out fairly closely after the event what activity has taken place.

53. This is very much involved with the best use of resources in the NHS in Wales. Certainly in my area a lot of patients get referred across the border and 60 per cent go out of the area for acute treatment and at least half of those go to England. We have been doing much more in-house surgery in community hospitals in Powys to try and avoid this but one of the problems that we have, and perhaps Mr Stansbie can address this, is we are never quite sure when the patients go to district general hospitals in England whether the money follows the patients back to Wales when they come back perhaps for recuperation into community hospitals. Is there good monitoring of that sort of thing going on?

(*Mr Stansbie*) There is better monitoring now than there was. The situation at one stage was that patients had a reduced length of stay in Shropshire and moved back into Powys for care and we were paying twice. That was clearly not sensible. I think we do have to make a distinction between the regular activity for which we have contracts and these out of area treatments which are effectively outside the contracts, which is North Wales' problem and to some extent all of our problems, where in the past we had to approve those and in the future they will simply go ahead and we will get a retrospective cost. I think it goes back to other points we were talking about. There are always border issues. I think there are problems, for example we were talking about people who are English who will be in Welsh LHGs and vice versa, and I think they are going to be confused because the patient's charters are different in England and Wales. As you know, we have had some difficulty with that in Shropshire. I think these cross-border issues are always difficult I think what we are keen to do is make sure the system is as robust

[**Mr Livsey** *Cont*]
as possible and secures the health of the people in Wales as best it can and out of area treatments is an area that we will want to continue to monitor very carefully

Mr Caton

54. Amongst the particular pressures the NHS faces you refer to the fact that the cost of medical negligence claims is rising by £3 to £5 million a year and that was highlighted by the Comptroller and Auditor General in his recent Report on the NHS Wales Accounts. Are you satisfied with the cost effectiveness of the Wales Risk Pool?

(*Mr Kelsall*) First of all, I have to declare that since the end of last year I have in fact been the Chairman of the Wales Risk Pool. Yes, I think it is a very effective organisation. Since 1996 the administration has been undertaken by the Welsh Health Common Services Agency and I think they have done a very good job indeed. I am very impressed by the administration which is extremely slim, I have to say. I think I am right in saying that a similar organisation in England is very, very much bigger in administrative terms. As a small organisation in Wales it has performed extremely well. If you would like me to give some of the reasons why there have been increases I will gladly do so.

55. Is it true that some authorities are taking commercial insurance against non-clinical risk?

(*Mr Kelsall*) Yes I think some are. I am not sure how many but against non-clinical risk I think there is one trust. I am not quite sure which one that is. I understand it is one at the moment, Chairman.

56. Why would that be?

(*Mr Kelsall*) I do not know because quite clearly going through the risk pool should be much much cheaper in that there is no profit element involved. I think this is something that the Department of Health has taken up in England as far as health insurance is concerned. To me the efficient way of doing this is to go through the pool.

57. What are you doing to minimise risk?

(*Mr Kelsall*) A great deal. We have introduced a whole risk management programme which came into effect last year and which is now compulsory on all trusts. They all have to follow 12 particular standards in risk management and they are audited on those so there is a very great drive indeed to bring the number of claims down and to reduce the risk.

58. You are satisfied that those standards are a good measure of performance?

(*Mr Kelsall*) Yes, very happy indeed, it is working extremely well. What will drive that in future is that the premiums which trusts pay will be geared to their performance against the standards so that will be a very clear driver and the trusts which have a bad assessment will find themselves paying higher premiums.

Ms Morgan

59. It seems that the development of drugs is going to produce a major need for increased resources in the NHS. In my constituency is the Velindre hospital where they do clinical trials so I am well aware of the issue of drugs being developed and that will have a good effect on cancer patients in particular. But the issue is about how we are going to fund those drugs. I wondered if you could comment on that. I think you said that primary care drug expenditure will increase by £30 million in the coming year. How do you see the long-term prospects of coping with this issue?

(*Ms Aikman*) Obviously it is an extremely difficult issue because a lot of drugs are being developed and that means we are able to treat more patients more effectively. I think what we are doing alongside that is trying to reduce some costs in drug areas and in particular in Wales we have got an All-Wales Medical Forum which is looking at utilisation of drugs. Quite a lot of health authorities now have got a committee which sits across the health authority and the local trusts so that we can have a look at the cost-effective use of those drugs between the hospital service and the primary care service because in particular we find that drugs go cheaply into hospitals and more expensively into the primary care sector and we are trying to find better pathways through that. Our local health groups now are developing formulae and I am sure there will an fair amount of peer pressure around now. Perhaps one of the suggestions we could make is that there needs to be an effective incentive scheme for reducing drugs, in other words to give an incentive to general practitioners perhaps into the practice budget arrangements which makes them much keener to ensure that they are making the most cost-effective use of the funding that they have.

60. Do you think GPs prescribe drugs unnecessarily?

(*Ms Aikman*) I think that the GP fundholding scheme has shown that GPs make an effort when there is an incentive in the system to make sure that the prescribing is cost-effective. I do not necessarily mean that they prescribe drugs which are not needed, only that they make sure that those are a generic drug rather than a branded drug and therefore are normally cheaper.

(*Mrs Williams*) I think there are huge cultural issues in Wales about the use of medication. For example, if I take our own area people in Swansea are three times more likely to be on medication than people in Durham which is a comparable city. There are huge cultural, societal issues about people's responses in Wales in terms of looking at for drug regimes and I think that is clearly a huge educational issue we will be wanting to work with the Assembly over in terms of how do we educate people.

61. They go to the doctor and expect to come back with a bottle of tablets?

(*Mrs Williams*) I think that is a big issue in Wales.

Mr Caton

62. Is it partly about educating the doctors in Wales as well? It takes two.

(*Mrs Williams*) That is right.

(*Mr Stansbie*) I think the other area that was mentioned is the new high-cost drugs which are coming in of which we have had a number in recent years. One of the things the health authorities have done is to set up an all-Wales Forum to look at new drugs coming not only from the point of view of efficacy but also value for money because we cannot ignore the fact that these drugs are expensive and if they are inappropriately prescribed that is money that we could be using elsewhere. It is going to be a growing area because we know from the drugs companies that they have a lot of drugs in development that are very effective but very expensive. A number of those drugs will stop other procedures. Years ago people used to have operations for duodenal ulcers, they now get treated with medicines. One of the problems in the Health Service is that we need to make some brave decisions about bed capacity because when those beds are not used for that they get used for something else because of the pressure in the system. These are areas we are going to have to work out very carefully over the next few years as new and usually very expensive drugs come into play.

63. One of the other issues is availability of drugs in different areas in different health authorities. For example, the latest drugs for ovarian cancer are prescribed in different ways and their availability is different in different parts of Wales. Obviously this all-Wales body will improve that situation but I think the situation is still true at the moment that in one health authority in Wales you can get a drug for the treatment of ovarian cancer which you could not in another authority.

(*Mr Stansbie*) That is exactly why we set this forum up to try and make sure we can do it across Wales. It is very difficult because some of these drugs are very expensive and particularly for a health authority that might have a specialist centre it can tend to have higher costs because more people go to the specialist centre. Again, it is not an easy situation but I think all of us are more comfortable at having an advisory group that can look across Wales at these very difficult decisions. I have to say it is not all about money. There are big issues about the efficacy and effectiveness of some of the new drugs that come in and particularly the way that they are prescribed within various clinical protocols. Quite often new drugs do have to be worked through by specialists before they can be generally released and that can lead to differences in the way people are treated. We are hopeful having set up the group that it will give us a better handle on what is a very difficult and what will continue to be a very difficult area.

(*Mrs Williams*) One of the other issues that causes difficulty is the international dimension that some drugs are more easily available and much cheaper in some of the European countries, for example, than in Wales and people know about this and hear about it and there is the Internet and it really does cause a big problem.

(*Mr Stansbie*) One of the things GPs are telling us is that patients come into their surgery having surfed the net to tell them what drugs they need. That is very difficult particularly where there is a culture where people do expect to get drugs. Mrs William and I have recently been talking to some of our colleagues about Europe and one of the issues we will face is the European market because that does mean it is likely there will be free movement of drugs and other procedures in the future. This is an area which I suspect we will be returning to over the coming years.

Dr Lewis

64. Have you any evidence that drug companies are overcharging for new drugs and do you have any machinery to try and put pressure on them not to do so?

(*Mr Stansbie*) I do not think we have that evidence. I think there is a lot of research within the NHS about drug companies prescribing and within the national framework. The drugs companies of course say they do need to charge high prices initially for drugs to back up their research. I think what we are more concerned about in the NHS is the practical implementation of new drugs particularly where patients have their expectations raised that this new drug will do things that perhaps it will not do for every patient. I think what we are finding is there has to be increasing work done between the NHS and the drugs companies to manage this process. Certainly I think the question of drugs costs will be a growing issue particularly for the Assembly when it comes into being.

65. Are you concerned that some groups of people suffering from particular ailments—I have in mind particularly AIDS—have very effective lobbies working for them whereas other groups such as those suffering from schizophrenia are much less forcefully represented? Are you aware of the recent concerns expressed by the National Schizophrenia Fellowship and SANE about the fact that new drugs are available for the treatment of schizophrenia which appear to be remarkably efficacious and basically life-savers and yet on the grounds of expense it is a complete lottery whether you get prescribed them or not?

(*Mr Stansbie*) I hope in Wales it is better than a complete lottery. We have done a lot of work on this, as we say. I think the Confederation in Wales takes very seriously the issue of how you balance what can be very powerful lobby groups with the views of other people who naturally do not have powerful lobby groups and I think schizophrenia is a relatively powerful lobby group not because of the schizophrenics but because of the families. There are other groups of people, particularly the elderly in the population, particularly the elderly mentally infirm in the population where I think we have a duty in the NHS Confederation, as indeed do health authorities, to try and ensure that we balance those lobby groups. It is difficult and again I think we have a duty to say these are not simple issues. For example, some of the cocktails of drugs that treat Aids are now very effective and there is this constant balance we are trying to strike between the pressure groups who want naturally the best for whoever they are

[**Dr Lewis** *Cont*]
representing and what is good and effective. One of the roles of the Confederation in Wales is to try and make those balances, difficult though they are.

66. Thank you very much for a very good answer, if I may say so. On fluoridisation you say on page 4 that if that were to occur it would save NHS Wales £50 million a year. How have you arrived at that figure? Where in the United Kingdom does fluoridisation take place and with what effect?
(*Mrs Williams*) We have based our calculations on the fact that about 65 per cent of the resource spent in the primary dental service is on caries and issues of that kind. That is where the actual figure came from.

67. Where else in the United Kingdom is it practised? Do you know that?
(*Mr Stansbie*) Can I come in because both my children have been brought up in totally fluoridated areas, that is Warwickshire and the West Midlands. There are lots of issues in fluoridation but as someone whose mouth is full of metal I am proud that my children do not have any fillings between them. I think that is an indication of how powerful fluoridation is. There are issues about fluoride and they will have to be discussed in the Assembly. I think Jan has some figure there quoted by the Minister.
(*Mrs Williams*) Mr Jon Owen Jones said in a written answer recently that since the cessation of fluoridation in Anglesey tooth decay in young children had increased by 168 per cent. I think that is quite a telling figure.

68. When you arrive at this figure of £50 million are you assuming that fluoridisation would wipe out the entire bill for caries or only a percentage of it?
(*Mrs Williams*) 65 per cent.

69. So you are working it on that basis?
(*Mrs Williams*) Yes.

70. Can you think of any other areas where, by adding chemicals to the water supply and medicating the population in this way, the NHS might save money?
(*Mr Stansbie*) Fluoride is a naturally occurring substance is the first important thing to say. People in this country are getting fluoride in the water naturally. This is about balancing the right amount of fluoride in the water. It is not adding a chemical. Everything is a chemical but it is a naturally occurring substance. Personally I can think of no other area where the Health Service has consistently said this would be good for people's health and which has proven to be efficient and effective and so on.

71. You are not worried that somewhere down the line we might find that there were enormous claims being made against the NHS for some long-term effect that had resulted from something that had not been anticipated?
(*Mr Stansbie*) We have been fluoridating now for sufficient years to see that that is not the case. Fluoride is naturally occurring and there are experiments across the world that show it does not have any detrimental effects. There are issues and my health authority and I suspect others will have to debate the issue of pure water and other things, but I think all five health authorities in Wales are very keen to see this because it is safe, it is effective and would save not only money but of course suffering.
(*Mrs Williams*) We do have a very detailed report and feasibility study we have done as five health authorities and we can send that to the Committee if you would find that helpful.

Dr Lewis: You are obviously champing at the bit to introduce it. I feel you may be glossing over the degree of controversy that attends this issue.

Mr Ruane: Flossing over!

Dr Lewis

72. Or even, as my colleague says, flossing over—and I did try to restrain myself by not saying you had got the bit between your teeth! Can I ask you this: do you believe there are any plans to introduce fluoridisation in Wales?
(*Mr Stansbie*) The report we have sets out what the technical issues are for implementing fluoride in Wales and certainly our view (and our committee recommended it also to the Assembly candidates) is that we should fluoridate the water in Wales as soon as we can. That is the view of the health authorities. We are not assuming it will not be controversial but I think as health authorities in Wales we have to take a stand on what we believe is right.

73. I know you are taking that step but what I actually asked is have you had any indications that there are any plans to introduce it in Wales?
(*Mrs Williams*) I think we will have to wait for the incoming Assembly to take a decision on it. We have no such advice at the moment.
(*Mr Kelsall*) Just dipping into the recesses of my mind going back quite a long time there was a proposal years ago for fluoridation in Anglesey. I am not sure whether it went ahead and then stopped. I think I am right.

Chairman: It would be very interesting to see the evidence that there are no harmful effects because I am not aware there have been a great deal of studies into the possible harmful effects. I know it is very good for dental caries but I am abusing my position as Chairman when I say I do not believe that it is something one should be doing to prevent a non-fatal disease in many cases. Fluoride is not naturally occurring everywhere, otherwise it would be a different matter. Mr Ruane?

Mr Ruane

74. It is a huge amount of money we would be saving, £50 million a year, bearing in mind you were given £18 million in 1998- 9889 to reduce waiting lists, it is almost three times that amount. That extra money would be welcome. How long would it be before that money came on line and, secondly, what proportion of the population in Wales live in fluoridated areas?
(*Mr Stansbie*) In terms of the saving it is a saving that would occur to the NHS. I suspect the health authorities would not see any of it partly because of the way that the dental service is funded. I still think it would be a saving to society and that is something we have to take account of. My understanding is at

[**Mr Ruane** *Cont*]
the moment there is no part of the population in Wales since Anglesey stopped that are getting fluoridated but there are other parts of the UK.

75. What proportion of the United Kingdom lives in fluoridated areas?

(*Mr Stansbie*) I do not know but again we can let you know that if you would be interested. I think it is worth sending the report that we have because it covers a number of these areas.

Chairman: I think we would be interested to see that. If we can move on now. Mr Caton?

Mr Caton

76. You welcome the opportunity to work under the leadership of the National Assembly. How do you think the National Assembly is going to affect your work and how are you preparing for it?

(*Mr Kelsall*) We think it will have a very considerable effect on our work as the NHS Confederation. First of all, Chairman, we clearly see there will have to be a close relationship between the Assembly and particularly members of the Health Committee and the NHS Confederation as well as with individual health authorities and trusts. So we do see a situation where the kinds of meeting we are having today will be increased considerably. We very much hope that is the case because we want to work with Assembly members. Since we take a very large proportion of the overall vote it is very important we do account for ourselves as to how we are spending that money and also explain other difficulties and problems. As for the future we very much hope that the Assembly will take a strategic view. We very much hope that individual Assembly members will not become too embroiled in very local issues like closures of hospitals and that kind of thing. Clearly they will want to discuss these things but what we hope will principally come out of the Assembly is a strategy with which we can get involved.

(*Mrs Williams*) The five health authorities of Wales produced a key issues paper recently that we circulated to all Assembly candidates and we would want to use that as the basis of discussions with incoming members and members of the Committee to engage in a dialogue in terms of the major issues facing the Health Service in the next century. So we have attempted to set out the issues. We also recognise of course that the governance arrangements will change. We will be accountable to the Assembly. We welcome the opportunity to be open and transparent in the conduct of NHS business. We very much look forward to the dialogue between health authorities, trusts, the Confederation and appropriate committees of the Assembly.

Mr Thomas

77. Do you think there is a need to educate not only Assembly members and politicians but also members of the press and the media generally because there are many who feel that the press, particularly the local and regional press, take up very superficial views particularly when it comes to difficult decisions like closing hospitals where there may be a real objective case to do it in the interests of the community at large but the whole thing is whipped up in a sensationalist way and becomes a superficial exercise. My own view is I think that is a problem that needs to be grasped. I do think and I am asking you whether you think there is a need to really embrace the media and the public at large and educate them about the enormous range of challenges that you have very lucidly begun to explain today.

(*Mr Kelsall*) Chairman, I think that is absolutely right and I believe we in the Confederation must tackle that particular project. We have been therefore strengthening the NHS Confederation in Wales recently with the appointment of a permanent director and additional staff and I certainly see, dare I say, that the education of members of the Assembly concerning health matters and also education of the media will be a vital role we have to play. We have to do very much more than we have done. Perhaps to some extent it is our fault in that we have not put our views forward sufficiently in the past and we are attempting to rectify that. We are limited by resources I have to say but certainly we are paying very much more attention now to the media and public relations than we have in the past. We have to be conscious of the cost of course because what we must not do is take money out of patient care.

Chairman

78. Can I finish up by asking you a specific question related to your position as Chairman of East Glamorgan NHS Trust. Could you explain to us why it is proposed to close the Talygarn rehabilitation centre?

(*Mr Kelsall*) Yes I can, Chairman, and I am very pleased to do so. Talygarn was providing originally a service for virtually the whole of South Wales, probably a population of about one million but since the late 1980s/early 1990s area health authorities have developed a policy of providing their services locally. They have taken the view that it is better to provide rehabilitation services locally rather than having patients travel a distance to Talygarn and over a period this has been done. For example, the old South Glamorgan Health Authority removed the service from Talygarn to the Princess of Wales Hospital at Bridgend. They spent a lot of money there on a new rehabilitation unit and they did a similar thing in Merthyr Tydfil. At the same time the contract for Talygarn was taken away by Gwent Health Authority and they are handling their own rehabilitation work, and to a very large extent by Iechyd Morgannwg. Really Talygarn exists now only to support the population of Rhondda Cynon Taf and the intention of South Glamorgan and Bro Taf has been that those services should be removed from Talygarn to the new Royal Glamorgan Hospital when it opens at the end of October this year. Really what has been decided is that this should be a local district general hospital service and for the convenience of patients it should be located locally in the local district general hospital.

79. Is this why you say it would better meet the needs of patients who require rehabilitative care in that area? Is it because it is local or is there any other reason? We have a lot of evidence from people who say otherwise.

[**Chairman** *Cont*]

(*Mr Kelsall*)I have seen the evidence myself, Chairman. Yes, it will be local. The service will not be exactly the same because the service was originally designed for the whole of South Wales but could I say that we are intending to expand the facility at the Royal Glamorgan hospital. We have had detailed discussions with Bro Taf Health Authority on this as a result of which we do want to expand the facilities at the Royal Glamorgan hospital to meet the need. There is a degree of urgency in this because we hope to be taking over the hospital from the contractors at the end of April. If the service is going to be located at the Royal Glamorgan hospital there are several months' work to be undertaken before the hospital is due to open at the end of October. I think there are other advantages which we would put forward for having the service in the Royal Glamorgan hospital and the first is that diagnostic and treatment services are available on the spot in the hospital whereas at Talygarn they are some miles away from that kind of service. I would also suggest very strongly that the environment of a brand new state-of-the-art hospital will be very much better than the very tired old building at Talygarn on which very little has been spent for a long period of time. There is a bad maintenance backlog to be done, something like £1 million, and, thirdly, there will be financial savings to Bro Taf. We have estimates of about £158,000 a year by having the move and that money could then go into patient care in different directions. Those are the main reasons, Chairman.

80. As I say, we have had lot of evidence to the contrary of people wanting Talygarn to stay open and one of the things they are telling us is that specialist services are there which will not be available in other rehabilitation centres.

(*Mr Kelsall*) There have been two reports on this, Chairman, which conflict a little bit. There was a report done for Bro Taf by Dr Williams whose conclusion very clearly was that it was a district general hospital service and the rehabilitation service could be provided within district general hospitals. There was a second report done for the Coal Industry Welfare Organisation which suggested that not all of it could be done in the district general hospitals but in that same report they did in fact very strongly praise what was being done at the Princess of Wales hospital and at Merthyr as well so there is some conflicting evidence but we are happy, Bro Taf are happy and the local medical committees are all very happy that the service that can be provided at the new hospital will be perfectly satisfactory and meet the needs.

81. Would you say Talygarn has been the victim then of purchasing policies and the internal market?

(*Mr Kelsall*) Not necessarily, Chairman, and Mrs Williams might like to say something on this in a moment because Iechyd Morgannwg or its predecessor, I am not quite sure which, did remove services. I do not think it has been a question of that. I think it has been a question of wanting to provide services locally rather than having patients travel long distances. If I could just add I think a bit of sentiment has got mixed up with the medical argument as well because there are those who are very concerned about the future of Talygarn as a building which is a Grade II listed building. That, of course, is one of the problems because the cost of maintaining that building is very considerable and that will take money certainly out of patient care.

(*Mrs Williams*) Could I add in support of Bro Taf Health Authority and the trust, that West Glamorgan Health Authority took the decision to pull out of Talygarn on the basis that rehabilitation was a service that was needed close to people's homes and we have in the Morgannwg area a super department of physical rehabilitation at Singleton hospital and you have heard about the facilities in the Princess of Wales, and Morgannwg residents would certainly not swap the local service they have from those local district general hospitals for that in Talygarn.

82. Again, we have had evidence that there are specific conditions that are treated at Talygarn and the treatments are not available anywhere else. Ankylosing spondylitis is one that has been mentioned to us. Would you accept that as a fact?

(*Mr Kelsall*) As a non-medical man it is difficult for me to comment. Certainly very careful soundings have been taken by Bro Taf and of course there was an agreement by the Secretary of State that Talygarn should close. That ran out of time so there had to be a further period of consultation. I cannot specifically answer your question.

83. Would you consult your medical colleagues and get back to me?

(*Mr Kelsall*) Certainly[1].

(*Mr Thomas*) If I might just add to that, I think this is a good example of what is referred to in our document as hard choices. What the Health Service is very, very good at is developing its clinical excellence and keeping up with medical technologies and building new hospitals. What the Health Service is not so good at is closing the older, outdated facilities which have been re-provided. Those are the difficult decisions that health authorities, the public and politicians have to come to grips with. This is a very good example of that. You perhaps like me saw the piece on the news last night about the closure of the Cardiff Royal Infirmary where people were lobbying about its closure when we have a state of the art hospital open in the University Hospital on the same day. The Health Service cannot afford it all. It has to move forward, keep up with the pace of change but cut off the things that are no longer relevant.

Chairman: On that note we will move forward as well and move on to the next witnesses. Thank you very much for coming this morning.

[1] *Note from witness:* I am advised that during the last 12 months 37 patients with this condition were treated during normal treatment sessions at the current Talygarn facilities (there are no special clinics for this condition). I am also advised that there would be absolutely no problem in continuing to provide treatment for ankylosing spondylitis at the new Royal Glamorgan Hospital if the closure of Talygarn is confirmed by the Secretary of State.

Memorandum submitted by Dr Richard Kirk is printed on page 49

Examination of Witnesses

DR RICHARD KIRK, Paediatric Cardiologist, and MRS SUSAN BURNETT, Manager for Medical and Regional Services, University Hospital of Wales Healthcare NHS Trust, examined.

Chairman

84. Mrs Burnett, Dr Kirk, welcome this afternoon. Thank you for coming. I wonder if you could both introduce yourselves and explain your roles.

(*Mrs Burnett*) My name is Susan Burnett and I am the General Manager for Medical and Regional Services at University Hospital of Wales in Cardiff. My unit covers paediatric cardiac surgery and all adult cardiac services are included in the portfolio that I manage.

(*Dr Kirk*) I am Richard Kirk, a clinical paediatric cardiologist working at the University Hospital of Wales and I have done so since the unit opened in 1991.

85. Could you describe to us in simple terms what the congenital heart disease centre does, how many staff are employed, how many patients are served and what it costs the trust to operate?

(*Dr Kirk*) If I could address the clinical service. The trust employs two paediatric cardiologists, myself and one other, and there is a vacant surgical post which I am sure we will turn to later. In addition to that it has got the supporting services of junior hospital doctors, nursing staff and other ancillary staff. If you count everybody up there is something of the order of 60 people working in the University Hospital of Wales centre. The remit of this service has been to provide cardiac care for all these with congenital, ie, they are born with cardiac disease across the whole age range spectrum and that goes from the foetus through children into adult life and we cover 90 per cent of South Wales. Not all the local hospitals refer to our service but over the last eight years we have taken on board approximately 90 per cent of the workload in South Wales.

Chairman: Thank you, Dr Kirk. Ms Morgan?

Ms Morgan

86. When you say South Wales can you indicate where you class South Wales?

(*Dr Kirk*) It is perhaps easiest to do it by the district general hospital catchment areas and to mention those we do not serve through their choice—Aberystwyth, Abergavenny and there are one or two hospitals which choose between ourselves and Bristol. Liverpool serve the Aberystwyth unit and have done so for many, many years and Bristol serve the Abergavenny Unit. Bridgend is split and we take in the southern part of Powys, the Brecon type area. The more western side of Powys goes usually through Hereford and goes to the Birmingham provider unit and of course North Wales goes to the Liverpool unit in Alderhay.

Dr Lewis

87. Do you do anything in the way of screening people to see whether they are suffering from one of those diseases, which have resulted in the setting up of organisations like Cardiac Risk in the Young, where there are no apparent symptoms of anything going wrong until it is too late and a young person, often a very athletic person, is found dead.

(*Dr Kirk*) There are two aspects to screening. One is screening for plumbing type problems, holes in the heart and that type of thing and there is a fairly comprehensive programme in Wales as part of the ante-natal screening programme to which I particularly contribute in my role as my specialist interest is in the foetus. The second area is, as you rightly say, in those silent diseases that can cause sudden death. There is not a comprehensive screening programme in place in Wales and to the best of my knowledge there is not one anywhere in the United Kingdom. We are involved in screening however because many of the families are aware that screening can be undertaken, as indeed are the other health care professionals looking after them, and we are asked to provide a screening service for those families and indeed we do so.

88. But you only react to requests? There is nothing you initiate in that respect?

(*Dr Kirk*) Indeed.

Chairman

89. Can you tell me the cost to operate your centre? I think maybe Mrs Burnett was going to come in on that.

(*Mrs Burnett*) We have done an exercise looking at the full cost of the service and at the moment it is £2.7 million a year.

Ms Morgan

90. To go on to the present situation with the lack of a surgeon. The last paediatric cardiac surgeon, Mr Musumeci, resigned in August 1998 and so far you have not been successful in getting anybody else. Can you explain to us why he left?

(*Dr Kirk*) Perhaps I could address that problem really. Like all decisions there are several reasons why he decided to leave and perhaps without judging their importance I could say some of them. Clearly, Mr Musumeci and I developed the unit from 1991 and were close friends. It is fair to say that he felt that as a result of changes in cardiac care in South Wales, particularly with the adult service because he not only undertook operations on children but also on adults, he was becoming increasingly frustrated by the situation in South Wales and felt that he was not able to develop his surgical practice in the way he considered best for his patients. In mentioning that I would say that he felt that the decision to set up two

[**Ms Morgan** *Cont*]
cardiac units in South Wales for what is a relatively small population meant that the resources were spread fairly thinly and it was difficult therefore for either centre to become truly excellent. Secondly, as a consequence of the setting up of the Morriston centre and the ring-fenced funding, the University Hospital of Wales was asked to decrease its activity. It is an extremely hard thing for a surgeon whose work is of an excellent standard who has increasing demands on his services with rising waiting lists to be asked to cut back the number of operations he performs. That led to a large part of his disillusionment in working in South Wales and it became particularly acute as the University of Wales asked the institute to downsize the programme very much against the trust's wishes. Secondly, there was an issue in the sense that we believed that we were demonstrably providing excellent care for children with cardiac disease in South Wales. We have probably been the most rigorously appraised unit in the United Kingdom with perhaps the current exception of what is happening in Bristol. Over the last eight years we have had a report from the Welsh Office commissioned into our service, by Bro Taf Health Authority into our service. We volunteered to be part of the British Cardiac Society appraisal service and more recently we have had an appraisal by the Royal College of Surgeons. From the moment we started, we published our results to the Welsh Office, to the health authorities and to the paediatricians concerned and also through the Forum of the Welsh Paediatric Society we talked about the quality of results from the very beginning of 1991. Despite that we have not achieved 100 per cent referral of patients from our area. Hospitals have sent patients past our door to other centres, most notably Bristol, through a time when I believe it is fair to say that there was very little comparison in the quality of surgical results that the service were able to provide. Mr Musumeci and myself find it very difficult to understand how that could be the case. The next reason for him going was really the attraction for Rome. He is a Sicilian by birth. He had spent a lot of time working in the United Kingdom but there were lots of changes happening in health care in the United Kingdom which meant it was more in line with that in Italy and therefore the distinctions were not so large and he was heavily poached, if I may use that word, by a unit in Rome which was very keen to secure his services because they had a unit which needed someone to take them on and forward. So the prize for him was very great. It was a previously extremely prestigious unit in Rome where there were lots of things to be done and it was very worthy of his skills that a unit of that calibre should want Francesco to go and work there. There were the twin things of the pull of Rome and, if you like, the push from the Health Service and its organisation within Wales.

91. I think that has put it very clearly. I feel it is an absolute tragedy what has happened in terms of the service and obviously there are some questions we will need to ask of the Minister from the Welsh Office about the history of the way the cardiac work has developed in two split sites. Is it true that now your work in the hospital has gone up again that you are able to operate on more adults?

(*Mrs Burnett*) We are currently operating on 800 adults a year which is what we were asked to do following the opening of Morriston hospital. We put forward a business case to go back up over 1,000 cases and that is currently with the purchasers in Wales for their decision on the funding of that.

92. So it is not decided whether you can get back up to 1,000?
(*Mrs Burnett*) No.

93. When you went down to 800 it was from what?
(*Mrs Burnett*) We were at the time doing over 1,000, we were doing 1,150 because we had a waiting list of 150 at the time. We were formally contracted for 1,000 and it has gone down to 800 over the last 12 months.

94. One of the most difficult things for a surgeon to do is to reduce the level of operations.
(*Mrs Burnett*) It is extremely difficult for the unit as a whole. We had just opened a new Wales at Heart research institute. We want to be a leading edge centre. We want to be at the forefront of cardiac services in the United Kingdom and for a unit to take a cut-back is most unusual and it has affected everybody's morale.

Chairman: Can you explain why patients were pushed past your door and who made those decisions?

Mr Ruane

95. Who pushed them past?
(*Dr Kirk*) I can only give you a personal view because clearly I was not in a position to refer. I can tell you that when we initiated the unit in 1991 I visited all the paediatricians in South Wales and it was clear that they had their reservations about sending work to us. I could understand that because we were an untried, unproven team. We were fortunate in gaining the support rapidly of South Glamorgan and indeed Swansea and indeed Carmarthen and from that base we were able to provide good results. We very much hoped by publishing those results, which were considerably better than the United Kingdom average let alone some of the nearer units to us, that that would persuade people to send to us but, unfortunately, that was not apparently sufficient. We offered to do peripheral clinics in their hospitals because that is an important part of the work that we do. We do something like 120 peripheral clinics throughout South Wales but despite that they chose not to use our centre. I would rather not go beyond that and perhaps the questions would be better addressed elsewhere.

96. Who is "they"? You mentioned the ones that did not use you but you did not mention the ones that did.
(*Dr Kirk*) The units at Haverfordwest came on board when they saw the quality of our work and so did Newport. The units that have not used us are Aberystwyth, and I have some sympathy there in the sense they get a good service from Liverpool and in terms of distance they are, surprisingly, roughly equidistant. Of the more local ones, Bridgend only started to use our service last year after some

[**Mr Ruane** *Cont*]
considerable pressure from their health authority. Some of the paediatricians in Merthyr use our service but some do not and Abergavenny have never used our service always choosing to go to Bristol.

Chairman: In the light of the problems at Bristol it is probably not a good thing to have done. Is that right or perhaps you had better not comment on that.

Mr Ruane

97. Have they changed their policy since the bad publicity surrounding Bristol or have parents said, "We do not want our children to go to Bristol"?

(*Dr Kirk*) Paediatricians have not changed their policy at all although one must bear in mind that the surgical results in Bristol have improved enormously over the last three years. From the parents' point of view I know from experience over the last few months that if they are offered the choice of the Birmingham unit, with which we have formal links, or Bristol, they prefer almost without exception to go to Birmingham.

Chairman: We will move back to the subject in hand. Ms Morgan?

Ms Morgan

98. So you are obviously having a great deal of difficulty getting a new paediatric cardiac surgeon. Why are you having such difficulties.

(*Dr Kirk*) Again there are several reasons for it. The first is that in 1997 and 1998 there were 27 paediatric and cardiac surgeons undertaking operations in the whole of the United Kingdom and the vast majority of those, 80 per cent, have a similar job plan to Mr Musumeci, to whit a large proportion of their work was adults with a relatively smaller part children. There is only one training post in the United Kingdom for paediatric cardiac surgeons and as we speak their current trainee has not had sufficient training to become a paediatric cardiac surgeon or even a mixed practice so there is no home grown surgeon at the moment able to undertake this work. So we therefore have to look overseas and to employ a surgeon from overseas they have to meet the requirements of the General Medical Council and Royal College of Surgeons to come on its specialist register for cardiac surgery, indeed for cardiothoracic surgery and there is an anomalous situation in the United Kingdom in that we insist all surgeons undertaking cardiac work have a thoracic training and indeed a general surgical training as well. We therefore have had the frustration of good quality people working in paediatric cardiac surgery in established posts abroad who are unable to meet those requirements of the GMC and the Royal College of Surgeons training in the United Kingdom, and our training requirements in the United Kingdom are really at odds with those on the Continent. So that is an issue. The second issue is the length of time it takes to process their documentation to see whether or not they are registerable. To give you some kind of an idea we put out an advertisement for a replacement for Mr Musumeci shortly after he resigned which was around June. Then we had several good applicants for that post but none were on the specialist register and they had to go through that process and it took at least until December and then only two out of those candidates were registerable. So this has meant there has been a considerable delay in attempting to find suitable people. In addition to that, though, our profession at the moment is, as you might imagine, a little bit at sea really as a consequence of the inquiry going forward in Bristol at the present point in time and it has meant that the whole profession has had to stop and take stock of where our services are going and that has included, of course, professional advice from the Royal College of Surgeons. So we are in a situation where people are changing their ideas as time goes by and so when we were ready to re-appoint the post and to re-advertise knowing that we had candidates who had become registered the Royal College of Surgeons asked to review the service in Wales before they would sanction the reappointment of a surgeon to the service. They came down in January and a report was given to us I think at the very beginning of February, which is in the appendices we sent to you, and the Royal College of Surgeons have said that they will not support the appointment of a replacement for Mr Musumeci in its current guise but insist the unit merges with Bristol and effectively becomes a single service provided on two sites in Bristol and in Cardiff and unless that merger is agreed by the two departments and the College have seen the arrangements that have been put forward and agreed them they will not support the appointment of a paediatric cardiac surgeon at the University Hospital of Wales. We had a meeting with Bristol shortly after that report came through and further meetings have been tried to be arranged but one must understand that the public inquiry in Bristol began last week and the relevant personnel in Bristol have that at the moment as their greater priority than working towards an immediate resolution of the problems in Cardiff, and one can understand that.

99. It seems deeply ironical that we had a first-class service operating in Cardiff that has actually stopped and Bristol, which obviously had major problems, is in the position of now having surgery going on and we are in a position in Wales of not having any surgery in Wales.

(*Dr Kirk*) I think many of us feel that natural justice has not necessarily been served.

100. I think that comes over very strongly. So basically we are waiting for that agreement before we can actually advertise again for a surgeon. So what about the support staff and the unit, how is this affecting you?

(*Dr Kirk*) It has clearly been a major problem. We have been without major cardiac surgery now since September which is eight or nine months. We have tried to use the facilities to the good of children because clearly the facilities are not being used to anything like the extent they were before with not having a surgical side. The surgical side accounts for at least half the in-patient work if not more. So there has been a lot of slack in the system. Fortunately, we have two ward areas one of which is shared with the paediatric nephrologists who have been particularly busy in this spell so the staff have been working hard in that regard. In the intensive care unit the nurses are

[**Ms Morgan** *Cont*]
managing any child who requires intensive care whereas in the past the predominant use was cardiac and what spare capacity we had went to general. Now it is almost entirely general children. As you know, there has been an unmet need in Wales for intensive care for general children. If you like, Wales has had a free paediatric general intensive care service earlier than it might otherwise have expected. In that way we have tried to use the resources not only from the financial point of view but to keep the staff interested and busy. There will be an element of retraining if we are able to progress and re-provide a surgical service in Cardiff. We recognised that at the outset. We are familiar with that process in the sense we did that when we set up the service several years ago and we will happily go through that again. So the staff are gainfully employed but one must say pretty demoralised.

101. Are you confident that you will actually appoint a surgeon and restaff?
(*Dr Kirk*) I think that there are many elements that have to come together before I could be confident. I have been through a long and painful process over these last few months and to surmount one barrier for another to be placed in front of us is difficult. I would wish with all my heart to be confident but I feel I have to be somewhat circumspect in the circumstances.

Chairman

102. You say you do not have a surgeon in Cardiff. You mentioned something about an arrangement with Birmingham. Is that satisfactory and how is it financed?
(*Dr Kirk*) The timing of all these things came together, the Bristol problem emerging last year and Mr Musumeci resigning. We realised as we were one of the smallest units in the United Kingdom it made sense for us to link with another stronger unit because whilst we were able to provide virtually all the services for children there are one or two things that are extremely specialised and we recognised would be best served by being done in another unit. We felt that even when we had reappointed a surgeon it would be necessary for us to maintain strong links with another unit. Birmingham at the moment is one of the most respected units in the United Kingdom, probably in the world, and so it seemed very sensible to us to approach Birmingham and ask them if they would support us through a difficult period when we were without a surgeon and indeed to support us through the reinstitution of the surgical service. Clearly when a surgeon is appointed the spotlight will be on the unit and we felt to have the understanding and help of an established unit at that time would be very helpful to us. We were grateful in that Birmingham met us more than half way and have given us superb support over the last few months. The numbers of children, to give you some kind of an idea to date, is of the order of 60 since September. That would be in keeping with the activity levels that we have in Cardiff. The families of course would prefer not to have to travel the distance but nevertheless understand our difficulties and recognise that they are going to be centre of excellence and they have had extremely good treatment there.

Mr Ruane

103. You say that the Royal College of Surgeons will no longer endorse the appointment of a single-handed paediatric cardiac surgeon and is insisting that you join with the Bristol Children's Heart Unit to create a joint unit. Is this likely to happen in the short term and how would the joint unit work?

(*Dr Kirk*) The Royal College recognised that there was a difficulty with linking with Bristol at the moment because of the public inquiry and accepted that we may have to defer the actual mechanics of the link once an agreement had been made for it until such time as they were through their current difficult period so there was that caveat in there but nevertheless we still have to work with Bristol at this point in time to produce a concrete plan of a way of working forwards. We have put a proposal to Bristol which we are awaiting their response on. In essence we are proposing that there would be a single surgeon in Cardiff but that his leave arrangements would be supported by Bristol so that, for example, when he was on holiday if a child needed an operation they would travel over to Bristol to have that operation. It is surprisingly uncommon for someone to need an immediately urgent operation and indeed we have managed quite successfully for eight years in that scenario with Mr Musumeci. We recognise there is a professional issue, too, in as much as if there is a single surgeon working single-handedly it is possible to get quite insular. We have tried in the past to move away from that and it is not too difficult with the conferences. We are a relatively small body of people. There are 60 paediatric cardiologists and 27 cardiac surgeons so we meet fairly regularly anyway. Clearly there is very much to be gained from having regular meetings for discussions of the treatment programmes for children in a wider set up and we recognised that last summer and it was part of the Birmingham arrangements and we would be very happy to enter into a similar kind of arrangement with Bristol in times to come.

Chairman

104. What are the implications of the current inquiry in Bristol?
(*Dr Kirk*) I think that is very difficult for me to answer. It is a wide-ranging inquiry which will actually look at the provision of paediatric cardiac services throughout the United Kingdom, so I do not think it is going to be possible to easily second-guess it. What is clear is there is going to have to be far more openness in terms of publishing results, the kind of thing we have done in our unit over eight years, but I think the other units are going to have to do likewise. There may be an issue about the total number of units in the United Kingdom. There are 17 at the moment and one group feels that is too many and another group feel that is perhaps the right number. There are all these professional issues that are involved at the moment. It may well be that the

[**Chairman** *Cont*]
inquiry may radically restructure the provision of paediatric cardiac services through the United Kingdom or at least make recommendations.

105. Let's hope the problems of the past will not be repeated in the future. That is the best that can be hoped for from the inquiry.
(*Dr Kirk*) We would all echo that.

Dr Lewis

106. I have a number of questions I would like to ask arising out of what you have been saying. Can I say first of all without wishing to sound sententious that you do realise that these proceedings are entirely privileged and therefore this is your best opportunity to say anything that you have on your mind without having to worry about any threats of legal retaliation. This is your best opportunity. If you have any suspicions or fears or beliefs that something is being done wrongly now is your chance to take it. You do realise that?
(*Dr Kirk*) Thank you.

Mr Ruane: Get it off your chest!

Dr Lewis

107. On that basis there are two lines I want to pursue further. The first is the mysterious shunning of your services in the past. Trying to read between the lines of your diplomatic manner of putting it forward, I think it is fair to pick out Abergavenny as one that you regard as an area that was determined not to use your services. Is that right?
(*Dr Kirk*) I think that is a fair comment.

108. Right, why? You must have some idea. You do not have to be able to prove it. You might have a well-founded idea why this was happening.
(*Dr Kirk*) I think there are a couple of issues with regard to Abergavenny. Clearly geographically they are almost the closest to Bristol and so there is not much geographical advantage for them to send children to Cardiff. Time wise it is probably a bit quicker but mileage wise it is not much different. They have said to me that is one of their reasons.

109. Let me cut in at that point. There must have been times though—we hear so much about the pressure on the NHS—when perhaps Bristol would not have been able to deal with something and in the normal course of events they would say, "Right, let's send that patient to Cardiff"; but that never happened. Are you suggesting some sort of personal links or relationships or something that militated against you?
(*Dr Kirk*) No I am not at all and in fact they have sent one or two children to Cardiff when Bristol has been unable to take them. One of their comments to me has been the geography. The second to me is that Cardiff does not have a general intensive care unit, they just have a general paediatric cardiac intensive care unit and they felt the Bristol intensive care unit was of a more embracing nature and therefore would serve the children better.

110. You and your former surgeon obviously took great pride in what you built up and you must therefore have had thoughts and ideas about why some areas were shunning you. Are you willing to share those with us?
(*Mrs Burnett*) I think that is difficult. We put a lot of pressure on the health authorities to actually change purchasing practice and to make sure that all the children from areas like Abergavenny were sent to UHW because at the time some of those services were paying for our services and services in Bristol. Pressure has been brought to bear through the clinical route, as Dr Kirk has described, with conversations at various meetings in Wales and individually with them and also through the purchasing route and I think for a variety of reasons which Dr Kirk has explained and others you may wish to address directly to the individuals they felt they had a good service and they chose to continue to use those services. We did all we could to make sure that all the children in Wales were coming to us and, as Dr Kirk explained, there were several centres that chose not to for the reasons that he outlined which are very complex and very difficult.

111. Let me move on to the other strand of this, which is the attitude of the Royal College of Surgeons. I have been looking through this very substantial document and as far as I can see, correct me if I am wrong, the only relevant document from the RCS is the report on 21 January by Professor Marc de Leval who was appointed to take an independent look at the situation and then report back to the RCS. They then sent that report to the medical director at the University Hospital of Wales on 3 February. At paragraph 3.4 of that report it says, under the heading The Royal College of Surgeons's position: "Notwithstanding the excellent results of Mr Musumeci's surgery, the college"—that is to say the Royal College of Surgeons—"will no longer endorse the appointment of a single-handed cardiac surgeon. I trust that this view is also supported by the Society of Cardiothoracic Surgeons." So this man, who is doing this so-called independent report, is actually taking as his starting-point that you cannot go back to the situation of having your own surgeon. Why do the Royal College of Surgeons take this attitude? Have I missed something in the documentation or is there no further explanation?
(*Dr Kirk*) I think that there are two issues regarding their stance. I think it is fair to say it is not just their stance but the stance within the profession. The first issue relates to the quality and standard of work that can be provided. People have been saying a single-handed stand-alone surgical unit cannot provide good quality work. I do not think you can substantiate that viewpoint. We have proven that for eight years and there is not one shred of evidence from the United Kingdom Society data collected to suggest that a surgeon doing a small volume of work is any worse than doing a bigger volume of work and that data is available. The second issue relates to the issue of a single-handed surgeon is of necessity available for the bulk of the time. If we were to turn to Mr Musumeci, when he was working for us, for example, for the time he was in Cardiff he had some six weeks' annual leave and two weeks' study leave so

[Dr Lewis *Cont*]
for eight weeks of the year he had the potential to be out of the City of Cardiff. For the time he was within Cardiff he would be available were there to be a surgical emergency. I think it is quite reasonably considered that that is an unreasonable burden to place upon someone today. When Mr Musumeci and I were appointed in 1991 we both undertook our work on the basis that we were always available for whatever problem came through the door. In practice, of course, you are talking about a relatively small service, 100 operations per annum and the vast bulk of those being carried out in daylight ordinary office hours. Surprising though it might seem, it is exceptional to have to undertake a heart operation on a child in the middle of the night. With our modern treatments and drugs and things we can usually defer it to the next day or indeed a few days later and indeed that is often to the child's advantage because they can recover from severe illness, are stabilised and go into cardiac surgery when they are well. So although it sounds terribly onerous being available all that time the practicality is that you are not night after night after night doing operations and doing operations in the day. Nevertheless, one can understand that it is perhaps a burden on lifestyle that one should not inflict on someone in the 1990s in the way it was in the 1980s. Certainly the Society of Cardiothoracic Surgeons of Great Britain and Ireland, from my informal talking with their President, feel very strongly that that is an intolerable burden to place on a surgeon.

112. So, when we turn to the options section of this independent report, on page 3, paragraph 4.1 says about the option to maintain the *status quo*: "This is not acceptable to the College." Would you dispute that and say they are wrong to take that view although you understand their reasoning? Is that right or do you yourself feel that a link with either Birmingham or Bristol is the only way forward?

(*Dr Kirk*) I am absolutely sure that a link is the only way forward but in fact that link is already in place with Birmingham.

113. It is quite clear, reading between the lines of this report—and tell me if you think I am wrong—that what this Professor is really saying is he would like there to be a link and he would like it to be on one site, namely the site of the other hospital with which you are linked. In other words, he would like to shut you down and refer your patients directly to this other site. Am I right? That is what he is really trying to get at but he does not feel he can go that far because of the representations of the Welsh people and the Welsh Office who want your site to remain open?

(*Dr Kirk*) I certainly think Professor de Leval was placed in a very difficult position in writing this report and I think you have outlined it very succinctly.

114. Finally, would you agree with me that the most sinister aspect of his report is the last paragraph 5.5 where he says, "I suggest that a review of the joint services Bristol/Cardiff"—because that is the link he wants there to be—"should take place after two years. If unsatisfactory, consideration should be given then to the creation of a single centre on one site." Does it not really mean that he is trying to break the link with a site that gets on well with you, link you up with a site that you have not got on too well with in the past and whose whole reputation is under a cloud, to put it mildly, and then close you down after a suitable gap?

(*Dr Kirk*) Certainly one could put that interpretation on it. If you take the words as they are written then I would be very happy, as we have always been, to have open inspection and review of our work and we have always taken the view that we can only expect to undertake a surgical programme in children or indeed cardiological work if our results are as good if not better than anyone else's. I would very much welcome any review, as we have done in the past.

(*Mrs Burnett*) We would be arguing in that scenario that the centre should be in Cardiff. We are determined to keep the centre in Cardiff as far as we possibly can given the difficulties we have just outlined to you.

115. I think the Royal College of Surgeons seem to have rather a whip hand in this matter.

(*Mrs Burnett*) I appreciate what you have said but I am just putting our view that we would not sit back and say therefore that should be in Bristol.

Chairman: I am sure we would not sit back as a Committee. Ms Morgan?

Ms Morgan

116. You said earlier that there were 17 units in the United Kingdom and there is some debate about how many there should actually be. Would you say there was a case on geographical population terms for there being one of the units in Wales?

(*Dr Kirk*) The situation is in flux. There are currently four small units in the United Kingdom. There is Cardiff, Oxford, Leicester, Glasgow and Edinburgh and Harefield and there are already some changes going on there. The first task I understand of the new Scottish Parliament is to decide whether the surgical service will be provided from Glasgow or Edinburgh but it will not be from both. So those two units will be merging into a single provider for Scotland. Harefield is moving to the Brompton hospital next year so there is a trend towards smaller units merging with bigger units. If one were to take away politics, geography and everything else in the world I think it would be possible for there to be a single provider unit for Wales and the South West. Whilst it is possible to do that for work that came our way, if you have a bigger referral population then certainly the extremely sub-specialised areas of our work can be better catered for. So I think that there are arguments to be made for somewhat bigger units, but the geographical siting of these has bedevilled the profession since the early 1980s when there have been many recommendations to go from six units to more and less. We have gone round and round in circles over the last twenty odd years. Clearly it is very difficult to change established units and referral patterns.

117. The other point really is that it seems there is some evidence that the sort of person prepared to work all hours of the day and night, always on call

[**Ms Morgan** *Cont*]
with a great enthusiasm for the work is just the sort of person who produces a successful unit and I am sure there are lots of examples like that.

(*Dr Kirk*) I think that it is clear to me that in terms of the quality of the work what does not matter so much is the size of the unit, what matters is the quality of the people working within the unit and the way that they interact together and manage their unit properly. If you have people with good skills who work well together then you are going to have a high quality service and that to my mind counts far more than having big units, little units or whatever.

Chairman: On that note can I thank you and Mrs Burnett for coming this afternoon.

TUESDAY 30 MARCH 1999

Members present:

Mr Martyn Jones, in the Chair

Dr Julian Lewis
Mr Richard Livsey
Mr Elfyn Llwyd
Ms Julie Morgan
Mr Chris Ruane

Memorandum submitted by the Welsh Office is printed on page 53

Examination of Witnesses

RT HON ALUN MICHAEL, a Member of the House, Secretary of State for Wales, MR PETER GREGORY, Director NHS Wales, DR RUTH HALL, Chief Medical Officer, MRS ROSEMARY KENNEDY, Chief Nursing Officer, Welsh Office, examined.

Chairman

118. Good morning, Secretary of State. Thank you very much for coming. I wonder if you could introduce your team, please.

(*Mr Michael*) Certainly. On my left is Ruth Hall, the Chief Medical Officer. On my immediate right is Peter Gregory, the Director of the Health Department and on the far right is Rosemary Kennedy, the Chief Nursing Officer.

119. Thank you. Major structural change is going on in the NHS at the moment. At the end of this month GP fundholding will end and local health groups will be established. Contracting is being replaced by long-term agreements. Trusts and Community Health Councils are being reconfigured. Are you confident that the changes on 1st April will run smoothly? We understand that the Welsh Office Health Department is being restructured. Can you explain how and why?

(*Mr Michael*) I would be pleased to explain that as far as I can. I think it may help if I set out for the Committee a little bit of the background as I see it and then say a little bit about the changes in April and the financial arrangements. In the first instance, when I took responsibility for the health service on becoming Secretary of State for Wales at the end of October, I felt that there was a need to give a long hard look at the organisation and structure of the health service in Wales. I think it is fair to say that the health service that we took over in May 1997 was in some ways an organisational and financial shambles. I mean no criticism of the staff whose dedication was undoubted, from doctors to many managers, to nurses and to ancillary staffs, from cooks to cleaners. Their dedication has been undoubted throughout what has been a difficult period for the health service. In terms of overall strategy and the structures and organisation of the National Health Service, I think it was in a fairly dire strait. I think one of the most criminal acts of the previous administration was to cut out the senior management at a strategic level within the Welsh Office primarily during the period of the Secretary of State and the Right Honourable Member for Wokingham and I think that made it difficult for the Welsh Office to give the sort of strategic leadership that is essential if the health service is to be fully effective. There was the internal market which was destructive in its essence and we have removed that element of destructive competition in order to introduce an era where co-operation and effectiveness on outcomes are the places where the emphasis is placed. Certainly my own experience as a constituency MP—and I am sure many others have found the same—was that it was difficult to find anybody who was responsible for anything. The relationship between health authorities and the trusts and providers meant that wherever you looked for an explanation of decisions people were pointing in another direction. I think there was also considerable financial incompetence in the way that the health service was dealt with and again I think that goes back to Ministers giving the health service the structures and arrangements within which work could be undertaken. From May 1997, my honourable friend for Bridgend and my honourable friend for Cardiff Central grappled with those issues and when I arrived at the Welsh Office I found plans for reconfiguration of trusts a matter of days away from being announced. I supported entirely the intentions of that which was to strip out bureaucracy and to make sure that money was saved at the order of £7 million as an estimate in order to use resources for providing patient care as the priority, but I did not know that it was enough just to reconfigure the trusts. I felt that you had to make clear the philosophy and approaches and priorities on which the health service in Wales was being asked to operate. That is why I made the statement in the House at the beginning of December where I made it clear that the reorganisation of the trusts was partly to bring about those administrative savings, but it was perhaps even more about replacing competition with co-operation and about creating a single health service for each region of Wales which would bring together the acute services, the community services and the mental health services in a single seamless provision of care and which would also allow co-operation between the health service and local authorities particularly in relation to such services as those for elderly people and for children. In making that announcement I also tried to address the fact that Wales does not fit together very well. The geography, the population and the critical mass of health service provision in different places is problematic and that is why in different places we

[Chairman *Cont*]
came to different conclusions: for instance, Powys remaining as a single NHS trust despite its lack of an acute hospital; the different concerns of places like Carmarthen and Llanelli being respected; Llandudno general hospital being put with the north-west trust because of getting the critical mass right, although there is no doubt that Llandudno in terms of the community looks more to the east, and making arrangements between the trusts there which would overcome the perceived difficulties in order to provide reassurance. I may mention later the new arrangements for community health councils which are also meant to provide reassurance of the voice of the community in those arrangements. More recently I have announced the steps towards a stock take of the NHS both in terms of finances and in terms of the way it is run and the priorities that it is asked to work to. I think the advent of the Assembly and therefore its responsibilities in May could be seen in some ways as an opportunity to put things off. That is not the approach that I have taken with officials. What I have looked at is the best way to create the arrival of the Assembly as a way of setting the foundations, taking stock, getting the right sort of environment for the Assembly to be able to take up their new responsibilities, to work with the new management team that is being put into place and to make sure that the whole system works effectively. In other words, the Assembly needs to know what the problems are and to have a map of the geography of the health service in Wales in order to be able to decide what direction to go in and to work with both the in-house team in the Welsh Office and the local and regional teams to make sure that we develop a health service that actually delivers. The Audit Commission has agreed to be very closely involved with the stock take. I have discussed with the Chair and the Chief Executive of the Audit Commission the way in which the Audit Commission would be involved in the future and they have agreed to the part-time secondment of three individuals with different elements of expertise to help with the stock take and I am very pleased about that because the Audit Commission has increasingly been knocked about financial accountability and about quality and the delivery of the sort of services right across the board that the public has a right to expect, so I think that is going to help prepare the ground for the Assembly. As I have made clear on a number of occasions, the financial arrangements for the future show a sum of £1 billion additional finance going to the health service over the next three years. That must be targeted at patient care, but without the sort of stock take and making sure that we deal with the historic financial problems of the health service in Wales there will be a danger of that money being wasted or dissipated or it could disappear into the woodwork. So we need to clear the ground and make sure that we are moving forward with a common sense of purpose. We are also doing more to indicate the clinical priorities that have to be targeted and make sure that the clinical priorities that we are setting from the Welsh Office are understood throughout the service and aiming for clinical priorities and the outcomes are the issues that the Assembly is able to grapple with from day one. I think it would be very easy for the Assembly to arrive and become merely concerned with the proposed closure of a ward here or the reorganisation of a part of the health service there and it is important that the Assembly should be able to take an overview which is not just abstracted from the reality of local decision making but is very closely linked in with it. That is a series of steps which are the fundamentals of how we organise the health service and I would not pretend for a moment that everything has been put right as a result of those sets of decisions. What I do think is that the foundations have been laid. There are two other elements that I ought to mention. One is the reorganisation of community health councils on which I have made a recent announcement. What I did there was to reject both the alternatives that were consulted upon last year, that is that there should be community health councils that were health authority-wide or were ones that were NHS trust-wide because I felt both of those would be too large to represent discrete communities. A unitable organisation that is appropriate for the health service is not the same as the communities that people recognise and identify with and I hope that the outcome that I have brought out will overcome that problem because what it does is to create a federated structure. For example, Gwent currently has three community health councils and it was proposed that that would go into one in the original conception. CHCs in Gwent have put up a different pattern. What I have suggested is that we have one community health council for each local authority area, making five in all, which will be smaller in size than the old style community health councils and will be able to operate in a federated way so that there can be a single voice in discussions with the NHS trust and the health authority, but it will be able to make sure that, for instance, the areas of north Gwent and the Caerphilly and Islwyn areas feel that they have got their own voice into the health service and therefore the relationship between the community and the decision making of the trust and the health authority are matched to each other. There are a variety of other individual decisions which I would be happy to respond to but probably would not be appropriate to go into detail on, but, for instance, Llangollen is in one local authority area and in a different area in terms of health provision. I have tried to overcome that by saying let it be one with Wrexham in terms of the coherence of the community and speaking to its trusts, but let it have observers on the community health council that is coterminous with the local authority area so that there is communication between the two. When the decisions were announced about NHS trust arrangements in Carmarthen and Llanelli there was concern that Carmarthen might be about to be subject to asset stripping by Llanelli and that in Llanelli they might be subject to asset stripping from Carmarthen. I am satisfied that the new trust is actually trying to make a coherence of the two services the way forward and I think that is providing some reassurance to local people. There are other examples like Rhondda Cynon Taff and Merthyr where again the local authority, the geography and the people do not fit together and where I have made specific arrangements that suit that and I would be happy to explain the background to that if you wished. In other words, we are trying to make the communication the essence of the configuration of

[Chairman *Cont*]
the community health councils, does it fit the needs of the community to have a voice and the needs of the health service to be able to hear the views of the local community. Finally, the development of the local health groups which is going to be extremely important in creating a bottom-up approach to the commissioning of health care. I hope that that helps to set the organisational framework, but I think I should say something about the finances.

120. Briefly, Secretary of State.

(*Mr Michael*) The difficulty is, Chairman, that we have a background of very tight financial circumstances and some very serious financial problems which we inherited from our predecessors and I think that further progress on the issues that I have referred to and creating the right structures will not work under a clear financial framework. Last December I announced an extra £175 million for the health service which is a real-terms increase of 4.6 per cent over 1998/99 levels. I have also identified a further £53 million within the current health budget and expect to carry forward some £12 million from this year. That means I am able to allocate an additional £185 million to health authorities. £168 of the additional money will be included in revenue allocations to fund hospital, community and family health services, general medical services and the increasing cost of drugs prescribed by GPs. This gives health authorities an additional £134 million for hospital and community health services and that is a cash increase of 8.9 per cent, 6.4 per cent in real terms and £28 million to meet the forecast increase in the cost of drugs prescribed by GPs. That is good news for the NHS in Wales in meeting the full costs of the recent pay awards to NHS staff and giving a generous level of funding for the service and should give those local health authorities and trusts the right financial balance opportunities to develop their services. In addition I have put aside £18 million to fund unavoidable health authority and trust repayable loans, but the service has to play its part. Health authorities and trusts must operate and plan within the budget set and, wherever possible, start to repay outstanding loans. Some further short-term borrowing will be necessary, but I intend to limit it to the absolute minimum levels and on an understanding that the loans will be repaid to enable financial balance to be achieved quickly. As I made clear in the Welsh Day Debate on 25 February, my aim is that financial balance should be restored to all parts of the health service and again that is a part of providing a sound base for the future, otherwise we will just drift on with the health service believing that it will be bailed out each time a problem arises and that is very unfair to those parts of the service that manage their finances well and effectively. The new trust comes in from Thursday and that starts the new basis of collaboration, integration and coterminousity and I am very pleased at the way many of the new appointees are already working. I believe that there has been a change in the atmosphere with the removal of barriers and artificial boundaries to enhance that co-operation. Waiting lists are very important. Perhaps you might want me to come back to that rather than deal with it at this stage.

121. I think so. Perhaps you might finish your preamble now because I suspect you might want to expand on some of the questions that we are going to be asking in any case.

(*Mr Michael*) I think there are some points that I can come back to at the end if we have not covered them in the meantime. I think what I am trying to indicate is that there is a massive period of change ahead for the health service and challenge for it, but they are changes that are meant to increase the degree of stability and certainty for staff and management in the health service as well as for the general public.

122. Is there now going to be a period of stability? I think you have more or less answered that question.

(*Mr Michael*) Yes, I think so. The health service needed to know that there was effective management in place and a sense of direction from the Welsh Office and in future from the Assembly, from people managing the health service in Wales and knowing on a day-to-day basis where they stood. You asked me about the restructuring in the health service. Would you like me just to indicate—

123. In the health department?

(*Mr Michael*) Yes.

124. Yes.

(*Mr Michael*) At the moment we are recruiting a number of posts. Firstly, the Director of Operations who basically will be the Deputy Director of NHS Wales and will be a health service manager. Secondly, the Director of NHS Human Resources. There is nothing more important than the people within the health service and it is essential that that is recognised and dealt with at the very top level of strategic thinking. The third is the Health Services Policy Director and that is so there is an emphasis on the long-term planning and policy for the health service. Also, Health Promotion Wales will become the Health Promotion Division and so that will be strengthening the public health side within the top management of the Welsh Office and, finally, the Health Information and Monitoring Division or, as it is going to be described, Health Gain Division. So all of that is reshaping the top management team. You may want to hear from Peter, Ruth or Rosemary on the different aspects of that in terms of the detail. That will put the top management in place which can give comfort to the health service in Wales and certainly I found from talking to people around Wales that they felt that the stripping out of some top levels of management actually left them quite vulnerable in terms of local decision taking.

Mr Livsey

125. Secretary of State, first of all I would like to thank you for demonstrating your meticulous interest in the NHS as I believe you to be particularly interested in this facet of policy. I would like to thank you for the re-configuration of trusts which I think was done in an objective way and many of us are grateful for that. And I would also like to thank you for the decision on community health councils and the fact that there will 22 of them and they will be represent areas of community interest and I think that is absolutely vital. However, I would just like to ask you about the community health councils. I

[**Mr Livsey** *Cont*]
understand that the amount of resources available to community health councils, given their very important role, is going to be the same as it was previously and yet there are meant to be a few more community health councils. I am particularly anxious to know why it was that the decision was made only to have nine community council offices in Wales? This is very difficult for some of us in some areas where we have been given the right answer as far as the number of community health councils is concerned, but the ability to administer community health councils' work is going to be diminished by the fact that we are going to have to amalgamate offices. Certainly in my area it is a bit like administering Hammersmith from Chippenham in terms of distance. We feel very strongly about this because we have had very effective community health councils which I think got the message over to you about certain problems we have got, but it now seems that we are going to be a bit debilitated by our ability to administer community health councils properly and effectively.

(*Mr Michael*) In answering that question I am geographically challenged because I have not a clue about the distance from Chippenham to Hammersmith. However, I do have some knowledge of the distances between places in Mid Wales and so I understand the point that Mr Livsey is making. What I have promised is consultation with the Association of Community Health Councils on the way in which we take this forward. I spoke informally to representatives and said that I did not think that it would be sensible to consult further on setting out the areas to be covered by community health councils because I was pretty sure that the right answer was coming out and this federated approach would actually give communities what they were asking for in the comments which were quite critical about the original options that were consulted upon but I would consult on the way in which we carry it through. I am conscious that we are just coming to the start of a new financial year and a new appointment year and all the rest of it and there is a bit of raggedness and I appreciate that that is giving some difficulty to community health councils in the short term, but if we can at least make certain the shape of the map then we can work forward. I am trying to arrange an early meeting, although you will appreciate that getting things into the diary is quite difficult given the current pressures. The actual number is 28 rather than 22. The reason for that is to accommodate some issues that cut across local authority boundaries. One example is the Llandudno local authority area which is quite large and there was a need to offer reassurance and some targeted consultation in relation to both the short term and long term future of Llandudno general hospital and therefore I created two community health councils within that local authority area and that has been generally welcomed. The other most important example—I mentioned the Carmarthen Llanelli one earlier—is Rhondda Cynon Taff Merthyr where Cynon and Merthyr are one as far as the trust is concerned, but clearly as far as the local authority area is concerned the configuration is different. What seemed sensible to me there was to have separate community health councils for Cynon, Rhondda and Ely so that Cynon and Merthyr can work together in relation to trust issues, but Rhondda, Cynon Taff and Ely can work together in relation to the local authority configuration, so it makes the best of both worlds of getting both the community representation right and recognising both the local authority area importance and the NHS trust configuration. One of the ways to deal with this is to look for efficiencies. For instance, I referred to the Gwent area where you have got three community health councils and therefore three offices. We are moving to five which gives an increased number but smaller and therefore more coherent and it is clearly sensible to service them through one office which will probably be in Abergavenny and that gives the support that is necessary to the individual CHCs and the federation. I recognise that there are resource questions to be answered and we will look at that as we work through the processes and the consultation, but I think there are efficiencies that can be made by having joint servicing of community health councils which will be working together and that should help to offset the fact that there will be an increased number, but I am conscious that there are issues to be worked through.

Mr Ruane

126. The Committee discussed with Mr Gregory last July the poor financial position of the NHS in Wales. Your memorandum shows that the situation has deteriorated further since then. There is now a cumulative deficit of some £54.1 million, with 12 trusts now operating at a deficit. Are we to conclude that the NHS is underfunded, badly managed or both?

(*Mr Michael*) I think certainly there have been problems in several of the trusts in terms of the management of the finances and I think it would be simplistic to say that that is entirely due to bad financial management. There has been under-funding of the health service over a number of years. We have been seeking to put that right and, as you will appreciate, you cannot do that overnight. We are making a major increase in resources over the next three years, as I referred to earlier. What we have to do is to recognise that there are historic problems, that there are new configurations, new organisations, that we need to re-build a confident relationship between health authorities and trusts so that it is quite clear who is responsible for what rather than a confusing distribution of blame, if I can put it that way. I would bring it down to the additional funds that we are providing being accompanied by requirements on health authorities and trusts to be stringent in making sure that they are efficient in the use of available resources, the reorganisation that I have referred to being directed at making sure that money is used to target quality of service to patients in the community rather than the previous market competition. Finally, the stock take is very important. I was very keen indeed that the stock take should not just be a financial audit, it is an audit of performance and the way we do things as well in order to make sure that the new arrangements actually work, that the finances are realistic, that there is a look at how the cake is cut up and

[**Mr Ruane** *Cont*]
distributed to different parts of Wales to make sure that that is as near to being right as it can. There is never a perfect way of cutting up the cake.

127. What measures have you got to ensure that the money that you are allocating does end up with patient care and is not frittered away in a myriad of different directions?

(*Mr Michael*) The re-arrangement of the trusts with their responsibility for all the services in their area and for the delivery of services simplifies a lot of the structures. The advent of the new commissioning system with local health groups will help. It is a question of opening it all up and getting rid of the conflicts that have been there in the past. In terms of specific financial arrangements, perhaps it would be helpful if I asked Peter Gregory to come in and update you. I believe you have already had the financial update, but if he could come in in terms of the systems.

(*Mr Gregory*) I think the first thing to say is that we are putting in place from 1st April, for the first time in several years, a proper planning process based on health improvement programmes by each health authority. This will actually describe the health needs of the area, the service responses to that and how that is to be funded so that there is a proper planning process at a strategic level. Within that we are also looking for health authorities and the smaller number of integrated trusts to agree long-term agreements, which are three-year agreements for the provision of services and for their funding so that each side has a much clearer longer-term view about the way in which services should be developed and the funding relationships which underpin that. In addition to that and as a consequence of the stock take which the Secretary of State has announced we will be looking again—and I presaged this in July when I was talking about the sort of controls we had available—at the financial regime within which health authorities operate because there are significant differences between that regime and a much more stringent regime that trusts are expected to operate within and I believe it is time for us to look at whether that continues to be a sensible way of proceeding. We have a planning framework, we have got greater organisational clarity, we have got long-term agreements coming on-stream and I hope we can significantly improve the financial management systems which are available to monitor and steer the system.

128. Is there not a danger with having a new strategic level of planning and management at the top and local health groups at the bottom that the extra money coming in will be siphoned off to the bureaucracy either at the top or at the bottom?

(*Mr Gregory*) No, I think rather the contrary, in fact, because the arrangements which Ministers have put in place, including local groups, for the first time will provide a coherent, unified view about what localities need and as they develop their expertise they will be provided with the financial wherewithal that goes with the responsibility for advocacy for their health needs. So I do not have any doubts about the fact that rather than this being a siphoning off exercise, as health groups become more empowered they will take on more responsibility for aligning finances which are available with the services and the health needs.

(*Mr Michael*) I think it is fair to say that we are working through a number of difficulties. There was the hangover from the wage pay awards in 1998/99 which, of course, then runs on into current finances. There is a lot that has been going on in the current financial year and in what we are doing in the next financial year to create a stable platform for moving forward rather than just rolling your problems forward year-on-year and that is essentially the purpose of the stock take, both to make sure that money is going to the right places and to make sure that we are clear on the ground so that the health service is able to see its longer-term future. So out of that stock take should come greater detail for health authorities and trusts about how the finances in year two and three will be developed. I would expect during the course of the financial year that starts at the end of this week to be giving more detail of the longer-term perspective and that means that both the Assembly in going through that stock take process and people at every level in the health service will have a much clearer idea of where they are and be held accountable then for it. I think most people want to know where they are and then they are willing to be held accountable for it. What they do not like is the situation of being in the dark and feeling that blame comes at them from all quarters when they very often do not know where they are in terms of the resources to do the job and the decisions that are taken for reasons that are completely closed to them. I think the whole process that we are going through at the moment is difficult and messy for many people, but it is intended to bring that much more transparent and accountable system into place.

Mr Llwyd

129. A general question, Secretary of State, going back to the cumulative debt of £54 million that we have just heard about and referring to what you said earlier when you said that it is too simplistic to say there was mismanagement across the board, that there was genuine under-funding and I fully appreciate you will not change it overnight, I am being a realist. However, is there not a case for alleviation of that debt in certain instances? I appreciate what you said about patient care, the front-line use of the money and all the rest of it, but is there not a case for alleviation, at least in part, of some of those debts?

(*Mr Michael*) I think my personal answer will be I do not know and part of the purpose of the stock take is to be clear about how we have got to where we are in order to have a sound basis for moving forward.

(*Mr Gregory*) We are bound by Government accounting rules to treat indebtedness in a particular way and I think it would be very difficult for us to ignore that. What we actually want is a situation which is of sound finances where, although in a particular situation you might like to ease cash flow across a year, you are not looking to run the NHS, as the Secretary of State said in his Welsh Day Debate speech, on a basis on which we can only survive if you are giving hand outs and if you do write off debt then

[**Mr Llwyd** *Cont*]
there is the associated danger that you are actually encouraging just the sort of mind set that we want to discourage.

(*Mr Michael*) Additional money coming part-way through the year has undoubtedly helped. I was very pleased that we were able to put a considerable sum of money into alleviating the winter pressures, but in a way it is better for health authorities and trusts, rather than looking for extra money coming here and there, to know what they have got for the year and to know they can manage in times of pressure. Although there has been change over recent years, sometimes there is pressure during the summer and not only in the winter when hospitals and other parts of the health service know that there will be times of pressure. There may be a flu epidemic or cold weather resulting in illness and so on. I think we need to have good planning and long-term management which deals with the ups and downs rather than almost a crisis management. I cannot blame managers in the Health Service for dealing with their responsibilities in the way that signals have come from the Government in passed years. That is really why it is so important to draw a line under the past, why it is important for the stock take to get the messages across that we are recognising real difficulties within the health service, that we will listen to what health authorities and trusts have to say as well as undertaking the desk exercise along with the Audit Commission. We need to get that clear on the ground so that we have a fresh start.

130. There is no doubt that hitherto there has not been a recognition of the particular problems of the North Wales Health Authority. By that I mean that the North Wales Health Authority more than any other authority in Wales has to buy in a very large percentage of their specialisms. It is not the same for South Wales as they are blessed very often with in-house specialisms within the boundaries or confines of South Wales, for example, but quite a large percentage of the North Wales Health Authority budget goes directly to Merseyside, to Manchester, to various centres and Birmingham or Royal Shrewsbury. What I would suggest, Secretary of State, is that there should be an evaluation of this particular need in allocating funds and this is a matter that has been put to me by members of the health authority recently. They are concerned that they want to deliver a good service to the people of North Wales and unless there is a special recognition of this particular problem then I do not think they will achieve that.

(*Mr Michael*) I recognise the validity of what you say in terms of some specialisms. Historically North Wales has had the link to Liverpool and to Manchester to some extent as well. I think, in fairness, I should point out that obviously the situation in Powys has similarities where they do not have acute services and so for the Dyfed Powys Health Authority there are some issues that are comparable. All I would want to say is that this is an issue that can be taken up as part of the stock take. There are genuine issues in the points that you have made which should be taken on board. At the same time we must not allow that to become an excuse for relaxation on efficient use of the money available to the North Wales Health Authority and I am sure you would accept that entirely. I think I am happy to say that we will pick that up in the context of the stock take.

(*Mr Gregory*) Can I just make two additional points. We have been trying and so has the health authority to secure the development of some of those services in North Wales and the medium secure unit opened in November, the new cancer unit at Bodelwyddam is going to open in 18 months to two years' time and we have invested a very considerable amount of money in development of the Wrexham Maelor hospital. There have been efforts to try and locate these services much closer to the patients they serve. I think the key issue is does this constitute an additional cost to the health authority. I know there are costs to patients because they have to travel further, but if this is an additional cost to the health authority then it is an issue that needs to be factored into the way in which we do the stock take.

131. With respect, of course it is an additional cost and it costs a considerable sum over and above what it would cost in-house. I am astonished to hear you say that.

(*Mr Gregory*) In a sense most of these are tertiary services provided for very large populations. One of the issues around radiotherapy was it was going to be clinically and financially viable to provide the service at Bodelwyddam. As a consequence there is a considerable economy of scale in providing them in that way. If you adopt a provision of service for the smaller population then there are issues about clinical quality and there are also issues about costs.

(*Mr Michael*) One of the considerations in re-configuring the trust was to make sure that the critical mass of clinical expertise was available in north-west Wales and that was not a marginal consideration, it was an acute, central and crucial one. In doing that we had to make a judgment about what was definitely the view of the local community using Llandudno general hospital in order to put the care of patients first and in relation to this type of services perhaps I can again point to my own experience. When my father had cancer he had to go for treatment in the end at Clatterbridge on the Wirral and I certainly would put on the record my admiration for the quality of care that he received there both in terms of the clinical care and in terms of the attitude of staff. I could not have asked for anything better. Clearly the fact that service can be provided within Wales at Bodelwyddam is a positive step forward, but that decision has to be based on clinical need and the care of parents and if you look, for instance, at the priorities in relation to Powys, I think Mr Livsey and his colleagues argued very strongly that we should not just look within the borders of Wales and make the link with Ceredigion, we should look at the care of patients as the first requirement. I am very keen indeed and that is why, as part of the follow up for that decision, I spent time in Ceredigion and I met the health authority, met the trust, met the union representative, listened to what the public had got to say to make sure that the people of Ceredigion are able to depend on high quality care and the critical mass of services. But we do have to recognise that we have got a problem in Wales because our geography, our population and health service priorities are sometimes difficult to reconcile.

[Mr Llwyd *Cont*]

132. I am grateful and I hope that point will be taken on board in the overall view of things. Your memorandum tells us that "final decisions have yet to be taken" on the allocation of resources to health authorities and trusts for 1999-2000. Why has this decision been taken so late? Would you not accept that this makes planning very difficult with obvious consequences for the efficiency of services?

(*Mr Michael*) Yes, I would and it is not ideal, but that is all tied in with the decision that I took in March to have this stock take looking at both the finances and the organisation of the health service and it arises from doubt in my own mind about whether we were getting everything right and I wanted to have further meetings with officials and to ask some basic questions about the way in which we allocate resources, not least in order to make sure that the very considerable additional resources over the next three years are directed to patient care. I am now announcing the allocations but it is tied in with that element of the stock take. As I mentioned earlier, the intention is that coming out of the stock takes part-way through this financial year will give a clearer indication of the likely allocations for the following two financial years. As I indicated earlier, that is something that I think the Assembly will very much want to be involved in, but we are preparing the ground for them to be involved in a way where they have a real understanding of the decisions that have to be taken, the dilemmas that face us so that we can then take coherent decisions which give the health service a dependable future for the longer term. It would not have been my choice to be looking at these issues for the first time at the tail end of the last calender year and trying to look at them at a time when there was a whole range of other issues which required an urgent decision. So I would accept entirely your point that decisions are coming later than is ideal for good financial management and planning, but I hope you will recognise that in the long term it is because we are trying to get it right.

133. I am asking you a question and you are giving me the answer, I am not saying anything about that. On the subject of lateness of announcements, the cervical cancer screening project was supposed to be up and running fully from this Thursday onwards. My understanding is that there has been a considerable amount of work done and basically the service is ready for the off. This announcement has yet to be made and it is creating confusion and anxiety. There are problems with the staff service transfer and, frankly, it is a service that is overdue as well. When is it likely to be announced fully?

(*Mr Michael*) It is going ahead and it is a first for us in Wales and, as with many changes, there are uncertainties until you get to the point of decision and launch off, but I will ask Peter Gregory to come in on the detail.

(*Mr Gregory*) I think the Secretary of State has explained the reasons for the delay. In the light of the delay I spoke to the chief executive of Velindre NHS Trust two or three weeks ago to brief him on what was happening, to make sure that he and his staff affected knew what was going on. I gave him an assurance that we would make an announcement as quickly as we could. I gave him a nod and a wink that I was pretty sure it would be okay and as a consequence of the announcements that the Secretary of State has made today the National Service framework will start as quickly as the trust can put it in place. He told me that as long as they had a decision before the end of March they would be able to put it into place very quickly and he had no major anxieties about the effectiveness of launching this first National Service framework for cervical screening in the UK.

134. I asked you when it is being announced. He wants an announcement by the end of March. The end of March is tomorrow.

(*Mr Michael*) It is being announced today as part of the package of measures.

135. I am grateful for that.

(*Mr Michael*) I know the Chairman regarded my introduction as longer than would have been ideal, but I did try to keep it to a minimum in terms of the detail, but more information is being made available through the normal channels.

136. The NHS Confederation told us that the impact of wage awards in the coming year will be some £80 million and other workforce changes (i.e. junior doctors' hours, etcetera) some £7 to £10 million. Does the Welsh Office intend to provide additional money to meet these costs in full?

(*Mr Michael*) The overall increase in funding for the NHS increases by over £175 million over this year's levels for next year and, of course, we are aware of the pressures on health authorities.

(*Mr Gregory*) If I could just sketch a bit of the background because I think it will be helpful to you. The health authority discretionary allocations for next year—and these are the sums out of which the sort of issues you have just referred to will need to be covered—will be an actual increase of 8.9 per cent and a real increase of 6.4, that is significantly greater than has been provided for the NHS in a single year for a considerable period of time, certainly a greater increase than I can remember in my time as Director and before. So the background is that health authorities are being put in substantial funds in order to meet financial pressures which arise from activity, emergency admissions and pay and the other sorts of issues you described. It will be a matter for the individual health authorities in their long-term agreements with trusts to negotiate the impact of that, as you understand, I know, but the health authorities are going to be given an allocation which will cover the pay awards in full.

137. Therefore, you are confident that there will be no jobs lost in consequence?

(*Mr Gregory*) In consequence of the allocation which has been provided? I can see no grounds for that. The NHS is still faced with a significant overall financial deficit. This will go a considerable way towards retrieving the position but it cannot retrieve it entirely in a single year and so the trusts and health authorities will continue to have to look for a means of economising and reducing the level of deficit and living within their means in the way that the Secretary of State outlined earlier.

138. Is this particular element of funding going to be headlined at all or will it come in a main block that has been paid over?

[**Mr Llwyd** *Cont*]

(*Mr Gregory*) We will tell the health authorities how we have made the allocation, so we will be transparent about how the sum is made up, but it will come as a block allocation to health authorities through the usual formula.

(*Mr Michael*) I think it is worth making the point that in the health service, as in education for instance, the pay of staff is an important element. I think it is rather odd sometimes the way that things are separated out as if each individual element has to have fresh money coming in. Everybody knows that there are increases in salaries and wages for staff. What we have done this year is to make sure that the amount of money going into things like health and education is enough to deal with the backlog where sometimes they have been under-funded for predictable increases in previous years and where there has been the hangover, for instance, this year again in terms of pay and being able to deal with the in-year increases so that you stabilise the whole situation for the future. There is certainly enough resource going in to do that and also to see positive benefits in terms of direct patient care.

139. Mr Chairman, I would be very interested to have a break down of those figures with regard to every trust in Wales, if that is at all possible?

(*Mr Gregory*) I do not think we can do that simply because we do not allocate money to trusts.

140. If I could see the computation of the way you work it out.

(*Mr Gregory*) We can certainly give you that, although I have to say we have not worked this out in detail yet ourselves, but as soon as we can we will give the sort of breakdown of what the recurrent revenue allocations to health authorities will look like for the current year[1].

Ms Morgan

141. The NHS Confederation in Wales have described to us how emergency hospital admissions are increasing, not just in winter but throughout the year and you referred earlier to the fact that this rise is spreading out beyond the winter period. They argue that the extra money given last year was obviously very welcome, the £11.5 million, but really they need this all the time to keep up with the level of emergencies that they are having to deal with. You have sort of referred to the fact that it is better for the trust to be able to plan with a certain amount of money, but I just wondered if you could comment about the emergency aspects?

(*Mr Michael*) I think in general terms there has been a tendency in the way that the health service has been run over a period for them almost to be encouraged to come back with the bowl asking for more and very often having good reason for doing that. I think that is one thing that we want to change for the future and get behind us so that we end up with a realistic basis which is understood by everybody, which is seen as being reasonably fair (because you will never get perfection) and which gives people a reasonable framework for managing their resources rather than seeing each pressure as a crisis. Certainly we would want to do that whole process with people in the NHS. I do not think we can negotiate by headline in terms of them identifying problems they have experienced up to now, in terms of the sort of planning systems we are putting in place for the future, but perhaps it would be helpful if Peter comes in on how we have got to where we are at least.

(*Mr Gregory*) I think I have set out for you when I gave evidence in July, Chairman, that as a consequence of the very considerable difficulties we had three years ago, which I am sure you recall, there has been a very considerable number of initiatives to improve the management of emergency admissions, medical and surgical. It is important that we move, if we can, from a position in which small packets of money are provided to deal with specific issues to seeing the NHS for what it is, a whole and complex system which needs to be properly managed within a framework of policies and objectives and targets and a resource allocation process that is aligned with that so that issues which are longitudinal (because emergency medical admissions is not a one-off issue, it is part of the whole system) can be seen within the context of that whole system and not just as something we should worry about come November and that is what we are trying to put in place.

142. Obviously that would be the ideal situation, but these emergency situations may still arise.

(*Mr Gregory*) They will. I think we can be sure that they will. That means that there is no excuse for not planning properly and making the adequate provision in primary care, in acute hospitals and in community health services for the development of the appropriate response.

Dr Lewis

143. Secretary of State, if you were on a hospital waiting list which would matter more to you, how many other people were on the waiting list with you or how long you had to wait for treatment?

(*Mr Michael*) Clearly the consideration for any patient is getting the assessment and the decision on their particular case as quickly as possible. I have to say, though, that most members of the public also have a sense that they are somewhere within a hierarchy of priorities and many people will recognise, if they have got a condition that is not life threatening or excessively painful, that they will have to wait some time. There is obviously a trade off between being able to deal with those whose condition is life threatening or is deteriorating rapidly or involves a great deal of pain and inconvenience as quickly as possible. I am not sure that the question is the right one to be asking. The ideal is for the health service to be able to provide the care that is needed when it is needed. Clearly there are some issues. We have identified glaucoma as a condition where there is a deterioration in virtually every case and, therefore, eliminating queues there because people are bound to be getting worse, or in relation to cataracts for instance, while they are waiting. That has been a priority for eliminating the queues because it means that everybody is wanting the wait to be a minimum.

[1] *Note from witness:* The allocations were sent (*not printed*) to the Committee on?

[Dr Lewis *Cont*]

144. The reason I ask the question, Secretary of State, is that as you know on 23 March the NHS Confederation for Wales testified before us and these questions of waiting times versus waiting lists were featured quite prominently. Mrs Jan Williams, the Deputy Chairman of the Confederation, stated categorically that in her view—I am quoting from her evidence—"Where an individual is on a waiting list that individual really does not mind how many other people are on the list, what that individual is concerned about is how long he or she is waiting and particularly if they have a condition that is classed as urgent". That is the Confederation's view. Are you saying you do not agree with that?

(*Mr Michael*) I am saying that is in answer to a specific question on a specific day, it is a part of the truth.

145. So in other words you do not think that their belief that the Government is making a mistake by focusing on the size of the list rather than on the amount of time people have to wait for treatment, you do not agree with the view of the Confederation that the Government has got it the wrong way round?

(*Mr Michael*) I think it is always unwise if you are going to make a political point to try to do it by means of cross-examination. Obviously the size of the waiting list and the period that people have to wait are both important in terms of managing the responsibilities of the health service to try to give people the care and the treatment they need as quickly as possible.

146. Yes, but it was not actually cross-examination that brought this out because the NHS Confederation for Wales actually volunteered this view in the memorandum that they sent to us. If I can revert again to what Mrs Williams said. When she was asked, by me in fact, whether waiting times are actually increasing as a result of excessive focusing on waiting lists, she said: "We are certainly experiencing an increase in waiting times, particularly in outpatients" and she went on to say, "There is no doubt that if GPs see a long waiting list they hold back referrals. If they see waiting lists and times coming down then they increase the referral list and that is the consequence." So the NHS Confederation clearly are arguing that we should be considering waiting times rather than waiting lists in taking into account clinical priorities. Do you not accept that waiting lists may not be a very useful measure of performance?

(*Mr Michael*) I think that is a slightly convoluted question. Certainly as far as the way in which GPs take their decisions is a matter that it would be sensible for you to refer to them rather than to me. Certainly we target waiting lists and waiting times. We have recognised that both are important, as I indicated in my earlier reply to you, in managing the service in a way that meets the needs of patients which must be the priority. I was not referring to their memorandum, by the way, I was referring to your questions.

(*Mr Gregory*) Just to add one point to that, Secretary of State. It is very easy in a situation to believe that everyone has to wait a considerable time on a waiting list. The vast majority of people are seen very quickly, particularly if they are in need of urgent treatment in the view of their GP and the system accommodates that very effectively. In fact, the performance of Wales in that respect is at least as good as the NHS in England generally. Moreover, we are trying to ensure that when it comes to applying pressure to the NHS we do seek to contain the extent of the lists because that is a function of the overall activity, but also we try to make sure that people do not wait an unreasonably long time. Both of those are features of current Government policy.

147. I am sorry that the Secretary of State feels my questions are convoluted, I will try to follow his own model of brevity in the answers that he gives by putting it this way—

(*Mr Michael*) Good man.

148. Which is quite simply that you are saying in a sense that you want to have your cake and eat it, whereas the NHS Confederation for Wales is saying quite clearly that over-concentration on the size of the list is increasing waiting times and that is damaging and that priority should be reversed. Either you agree with that clearly stated view of theirs or you disagree with it. Which is it?

(*Mr Michael*) I do not think that you can abandon the purpose of seeking to reduce waiting lists but the reason for waiting lists is so that you do not have lots of people waiting for treatment and that has implications for waiting times. Nor can you ignore the fact that there must be priorities, both within any particular list in terms of what might be life threatening or painful and in terms of priorities between different conditions. The whole purpose of the stock take that I referred to earlier is to look at the way in which we spend money, look at the way in which we order our priorities and to make sure that the available resources are targeted at patient care and at outcomes. The length of lists and the time that people have to wait are two indicators that are important within the management of the complex animal which is the NHS in Wales.

149. Yes, but the Confederation is saying that you are getting the emphasis wrong accepting the fact that there is a trade-off between these two factors. They are saying that you are trading off too much against waiting times in favour of the size of the waiting list and you should adjust your priorities. Presumably you reject that. Either you accept that or you reject it?

(*Mr Gregory*) Before the Secretary of State comes back in can I say that I do not think that the Confederation's position is quite as stark as you are describing it. When I have had discussions with them about this we are in complete agreement that what is needed is a broadly based strategy for reducing waiting lists and the time that people have to wait. That includes initiatives that are currently going on in Carmarthen and in Bridgend to look at the prioritisation of waiting lists as relating to clinical need, which is strongly backed by the Confederation, and also are continuing efforts to reduce the number of long waiters on waiting lists. We are seeking, in our current waiting list initiative, to target long waiters in an effort to reduce the length of time that people have to wait. This is a double-handed exercise that we have in train. If there is a difference between us it is more a difference of emphasis than a difference of strategy.

[**Dr Lewis** *Cont*]

150. There clearly is a difference of emphasis because what they said in evidence was they very much hope that the Assembly will be "more flexible recognising that we do have the Government's commitment in terms of waiting list reduction and we would like a more sophisticated look at what maximum waiting times should be for general outpatients". I think people have got the point so let me move on to this question.

(*Mr Michael*) Before you do let me make the point that you seem to have isolated one sentence and put great store on it. As Peter Gregory has indicated there are continual discussions with those involved in the health service, including those you are quoting, as part of this complex web that is the decision making process of the NHS. What I have made clear right the way through my evidence to this Committee is that we are trying to bring a lot of these things out into the open in a way that is comprehensible, that is sensible, that is aimed at providing the care that patients need and an NHS that actually delivers. In order to do that we are going through a process in which the Confederation that you have referred to will be a participant in and will have a considerable contribution to make. I do not think we should just get stuck on a sentence in one piece of evidence nor indeed, if I may say so, your personal interpretation of that sentence.

151. You keep saying that it is one sentence. It is more than a page full of testimony on this issue and I have already quoted the same point being made repeatedly in that evidence that was given. This evidence will be published annexed to our report and therefore people will be able to read it and judge for themselves. Their view is perfectly clear.

(*Mr Michael*) I am glad you have read more than a sentence.

152. When you check the transcript you will see that I have quoted about three or four different sentences and there is more that I could quote. Let us consider another point that they made when they argued that the £18 million that they were given this year to reduce waiting lists needs to be recurring if the reduction is to be sustained. Do you accept that?

(*Mr Michael*) I not only accept it, it will be recurring.

153. Finally, your memorandum points out that you came into office with a pledge to reduce the size of the NHS waiting lists and it also says that you are on course to fall below the level which you inherited when you came into office in 1997 by the end of March 1999 and that is tomorrow. Is this not a rather modest aim for you to have had?

(*Mr Michael*) Not at all. You ought to recognise the mess that we inherited. If you are at the wheel of an oil tanker and you wish to be going in the opposite direction, you first have to take an amount of space in order to steer round in a circle to be going in the right direction. We inherited a period of rising waiting lists, mismanagement of the health service by Ministers and the wrong set of priorities in terms of decision making in the health service. I would be far more ambitious and the Labour Party would be far more ambitious than merely wanting to get back to the position that we inherited, but I think the process needs to be recognised for what it is. We have got very considerable ambitions for creating a National Health Service which is effective in delivering the service that people need, meeting patient need, hitting the right priorities. That is an enormously complex achievement to aim at, but it is the very ambitious one that we are aiming at.

154. So that we do not steer in too many circles I will leave it at that. Thank you very much.

(*Mr Michael*) Good.

Mr Ruane

155. Your memorandum states that one of the Government's "particular priorities" is to reduce health inequalities. Do you accept that this requires spending more per capita in disadvantaged communities?

(*Mr Michael*) I should say that you are right to underline the importance of the issue of health inequalities and it is one of the objectives of "Better Health: Better Wales" to address this and to bring the level of those with the poorest health up to the level of those with the best health, so addressing health inequalities is certainly a very serious priority for us. We are establishing an expert group to advise the Chief Medical Officer on the development of the system in Wales to monitor inequalities in health and health determinants and, where appropriate, to set targets. The main issues to be addressed include the selection of appropriate indicators for both monitoring inequality and monitoring improvements, so both recognising the situation that you refer to and monitoring the way in which we improve on that situation and the identification of appropriate areas across which to measure inequalities, are we measuring things across the right geographical areas, should things be monitored by an agenda and so on. Can I ask Ruth Hall to develop on the point?

(*Dr Hall*) I want to identify an issue around the potential of Health Action Zones, which is not a model which has been adopted in Wales but which is reflected in a separate set of structures and that is the proposals to establish local health alliances alongside local health groups and the implementation of those with a number of healthy living centres. I think you will be aware that there is £19.5 million allocated through the New Opportunities Fund for the establishment of healthy living centres and those three developments together will enable a much more local approach to addressing inequalities in Wales because we are aware that variations in health occur at very low population levels, they occur between almost adjacent communities. The need to influence from the grass-roots level upwards is one of the principal themes in "Better Health: Better Wales". So those are the principal ways that this will be taken forward. An expert group is in the process of being convened and it will, as the Secretary of State has already said, be identifying the baseline on which we can monitor progress with this very large and challenging initiative and also recognise that a multi-organisational effort will be needed to bring the levels of the worst health experience in Wales up to those of the best. We know that the gap is wide and that is also a key theme. The focus, in addition, is on children, on the workplace and on attempts to prevent illness

[Mr Ruane *Cont*]
rather than to focus on the treatment after illness has occurred and all those are key themes which I think will contribute to the effort to address inequalities. Perhaps I might also add that we are talking here not only about inequalities in health, but inequality in access to services and I think that is a key distinction and both of those elements are important.

156. I accept that within health trusts or a health authority area there are disparities or inequalities, but if it proves to be across Wales that different health authorities or health trusts have bigger inequalities than other areas then will you give a bigger slice of the cake to those health authorities? Is there an individual weighting allocated within the formula?

(*Mr Michael*) I think that goes back to the complexities of resource allocation which we were talking about earlier and, incidently, that is not just an issue within the health service, it is also an issue within local government decision making and one I was discussing with the Welsh Local Government Association as recently as yesterday. I think it is fair to say that this is the sort of cost-cutting issue that the Assembly is going to be in a very good position to deal with, not only looking at health as a service but looking at health as something which a variety of different services and organisations contribute to if we get the balance right in the way that "Better Health: Better Wales" indicated and it has certainly come up in discussions I have had with local government as well as discussions with people in the health service.

157. Will there be a strong steer from Cardiff to health authorities saying we expect you to eradicate these inequalities and we will be monitoring you?

(*Mr Michael*) I am hesitating slightly because I think there are two elements of inequality that are coming into the conversation. One is the health inequalities that arise from things like the industries that have been involved in an area or poor housing and factors like that and the other one is the inequalities of service, do people get the same quality of service, do they get it as quickly in Clwyd as they do in West Glamorgan or in Powys for instance and I certainly would accept that we should be seeking to make sure that the standard in every part of Wales is brought up to the standard of the best. There are differences of requirements in different parts of Wales, so we need to recognise the differences of rural and urban areas, old mining areas, old quarrying areas and so on. So there is a complexity, but both those elements of inequality I think are ones that are recognised both in "Better Health: Better Wales" in terms of the pathway forward that that mapped out and in terms of what we are looking at in terms of the stock take. The stock take is not just about money, it is about service and if there are issues about unequal service we need to get to the bottom of why that is and to be looking to improve that.

158. Moves to change the resource allocation for Wales to take better account of poverty and deprivation have been shelved pending a review in England. Could we not have taken our own decisions on this?

(*Mr Michael*) I think we are in the process of looking at our own decision making in relation to resource allocation which is part of clearing the decks for the Assembly. I did indicate earlier that the way in which we divide up the cake will be a part of the stock take in order that the Assembly is in the best possible position to understand the different issues that have to be grappled with and resource allocation and the form in which that is done will very much have to be part of that debate.

Chairman

159. We understand that the proposed model in England is for one district general hospital for about half a million people. Can we be assured that that is not going to be the case in Wales?

(*Mr Gregory*) I think you may be referring to the views of the Royal Colleges to the sizing of district general hospitals. I think Dr Hall will be able to give you some background on that. Can I just make two points. I think there is an increasing recognition that a simple sizing exercise is too crude actually to fit the circumstances of particular localities and, if carried to absurdum, would actually result in about three or four hospitals of any significance in Wales and they would be very large and very inaccessible. I think that one can take it to absurdum. The other thing is that we have announced that there is to be a review of acute services in Wales which Dame Deirdre Hind, the former Chief Medical Officer, will be leading which will be as a result of the All Wales Service Review which I mentioned the last time I gave evidence which is the most indepth study of any of the four UK NHSs which were conducted by health authorities, supported by the Department, some while ago. That will be looking at the way in which we reconcile the tensions of cost-efficiency, patient access, but also clinical effectiveness, particularly in an age of increased specialisation in the provision of clinical services. It is to try and square that triangle—it is not a circle—that we have set up the Acute Services Review which is shortly to get under way.

(*Dr Hall*) Perhaps I could just add, Chairman, that the Royal Colleges did in fact make a statement about the optimum size for district general hospitals but they do now recognise that view was taken in the context of their concern about sufficient capacity to allow some specialisation and also very much took into account the needs of the urban populations. The Colleges, and in particular the Joint Consultants Committee, have now recognised that they need to look at this again, that there may be the need for different models in different situations, and that more flexible approach is currently in hand. We will expecting further advice from them.

(*Mr Michael*) I think that further advice is extremely helpful because I think we all had concerns about, for instance, the fact that a hospital like Bryneglwys in its location clearly does not have the sort of population feeding to it that a hospital in the centre of Cardiff does. I think the fact that the Royal College now appears to be engaging in how you balance those two requirements is particularly helpful in Wales.

[**Chairman** *Cont*]

(*Mr Gregory*) It does go to Mr Ruane's point about resource allocation because it is a very good example of how you have to balance the issue of health need particularly associated with social deprivation and the relatively cost-inefficient provision of services in very isolated rural areas. There is a balancing act to be achieved there.

160. Has there been any consideration that we might have Health Action Zones in Wales?

(*Dr Hall*) I think that I explained earlier that Health Action Zones were considered and thought not to be an appropriate model for Wales in that they address a very large population base. We recognise in Wales that there are very considerable variations from one community to another and that we need to find a model which will properly reflect those differences. Very much taking on board the principles and the values and the sentiments behind Health Action Zones we have a model which is focused on a very much smaller population base and which builds on community action and community leadership and which brings in particularly the influences and participation of local government alongside health authorities and the NHS. The components of that I described earlier.

Chairman: I am sorry, I do remember now that you did mention that. Thank you for expanding on that.

Mr Llwyd

161. The NHS Confederation raised with us the problems of recruiting general practitioners, particularly in the Valleys and rural Wales, and also the fact that 20 per cent of the GPS are due to retire in the next five years. What is being done about this? Would you be in favour of a salaried GP service in disadvantaged areas?

(*Mr Michael*) Can I bring Ruth Hall in on the general current position.

(*Dr Hall*) The situation with regard to GP manpower and recruitment has been one which has been of concern for some time but the good news is that at the present moment there is the best coverage in Wales that there has ever been and the GP figures are at their highest. However, that does not mean that we cannot have regard to the variations around Wales in that. We are certainly aware that it is harder to recruit to some parts of Wales than others. The response to what is being done about it is that a considerable effort is being made at the moment through the Medical and Dental Educational and Manpower Committee which goes by the name of MEDMAC, to focus on general practitioner issues in order to establish the kind of informational database which has not previously been available in order to forecast needs. Whilst we are reasonably content at the present time that there is good coverage, we need to have a better means of forecasting the future and to take those needs into account very quickly. In that regard local health groups will be in a very good position to provide advice and to reflect locally what the situation is on the ground for them. We certainly will be looking to them to provide advice on innovative models of providing care through primary care in parts of Wales where we know that the traditional forms of providing general practice have not attracted practitioners. We are looking to them to provide advice to the Secretary of State.

(*Mr Michael*) I think I should make the point as well that the announcement of finances coming out of the Comprehensive Spending Review does include money to sustain and underpin the GP services. The point that you raised was the reason for that element being included.

162. I am a bit concerned about the statement that generally the cover is adequate or okay, as you mentioned just now, because quite clearly it is not and in many rural areas that I am aware of and in some Valley areas that I am aware of it is becoming an acute problem. The question I put that was not answered was has any thought been given to the possibility of a salaried service in these areas in order to target areas where the service is desperately important and it is going to disappear unless we are very careful?

(*Mr Gregory*) I do not think this is a one shot issue, I think there are a number of things that have to be done.

163. Yes.

(*Mr Gregory*) One of them is to provide more money for the development of primary care and, for instance, to improve the infrastructure of primary care. One of the problems we have is the difficulty of sustaining GP services is partly about the poor physical infrastructure of primary care in the sorts of areas you are describing. That needs to be tackled. The CSR announcement that the Secretary of State has made today is providing money to help with that. That is the first thing. The second is that we have been doing a lot of work to raise the awareness of those in primary care but more particularly those in health authorities, to the extent of the problem and the need to tackle it strategically. We had a major conference only a short time ago on exactly this issue in an effort to raise awareness. As far as salaried GPs are concerned, there is scope for the employment of salaried GPs, it is open for proposals to be made for the employment of salaried GPs, but I have to say that the take-up of those flexibilities has not been significant in Wales thus far which I think goes to the point the CMO was making about the fact that generally speaking—I do not think the picture is rosy everywhere, I would not dream of saying that—primary care in Wales is coping adequately. There are specific problems which need to be tackled through the health authorities and there also is a longitudinal issue about the age of many of the general practitioners and the need to anticipate the consequences of their retirement. We are trying to do that in the way that Ruth and I have described.

(*Mr Michael*) Can I say that earlier on there was a question about inequalities of services and certainly the inequality in terms of primary care is absolutely crucial in making sure that we do get quality of service. I think what we want to do is to recognise that there are problems in some areas but not to get that issue out of proportion and we certainly need to recognise where there are problems and to overcome them and again this is a part of the stock take, to recognise where there are issues that need to be addressed.

[Mr Llwyd *Cont*]

(*Mr Gregory*) One of the consequences of the approach of the establishment of the Assembly is that many NHS organisations, including the NHS Confederation, the professional bodies, the RCN, the BMA, the general practices organisations, are organising themselves to better represent their views to the Assembly. As a consequence of that we have been in much closer dialogue with the national representatives of GPs in Wales than we have ever been before and that is a very constructive dialogue which is trying to find a complex response to the issue of GP recruitment and retention and I am pretty confident that that basis of relationship we have established with the new General Practices Committee of Wales will be one of the ways in which we have an effective response to the problems that you are raising.

164. Is there a possible application of the scheme that was put in place, which was actually squeezed out of the right honourable gentleman for Wokingham, to assist in bringing dentists to rural Wales? You will recall that there is a policy where quite considerable capital grants were allocated. Is there no possible cross-reference there?

(*Mr Gregory*) I think the dental initiative, which is continuing, we have not abandoned it, has been a signal success and it does demonstrate the way in which initiatives from the centre can sometimes free up a problem in the way you describe. Of course, since in primary care we are talking about independent contractors, one has to work with the grain of what primary care feels is in its interest and in the interests of patients. It is not a simple issue. The flexibilities are available but there has not been much take up. I can promise you that this is an issue which is very much on our minds and I have no doubt whatsoever that when the Assembly is established it will be an area in which it will be expecting both the NHS and those like Ruth and myself and Rosemary, who advise the Assembly, to be making progress in tackling the problems that you have described, which I accept exist and need to be handled.

Ms Morgan

165. I am sure you are aware of Julian Tudor-Hart's work on Going for Gold which includes the idea of salaried doctors and I wondered if you could comment on his proposals.

(*Mr Gregory*) In detail I would be happy to if I could bring them to mind very quickly. What I would say is that the basic notion that there is a need for investment and greater flexibility in the provision of general medical services in the Valleys, which is the specific focus of Going for Gold, is one the Department would entirely accept. We have not yet in this context elaborated our discussion about health groups enough because there is so much that central initiatives can do in a way. Part of the response to continuing with vital high quality primary care is for local health groups to take this issue seriously. I think we would be looking for the kinds of initiative that Dr Tudor-Hart has suggested to be evaluated and, where appropriate, taken up by local health groups as the way of responding to the specific and special needs. What we must not slip into is the mistake of thinking that we can define these issues simply on the basis of geography. There are some quite excellent primary care services being provided in the Valleys and in isolated rural areas. What we need to be is discriminating about the way in which we underpin the development of primary care. In my judgment that is best done initially through an appreciation from the local level but then reinforced from the centre in the light of that and that is what we are trying to do.

166. I am not certain from your answers. Are you generally in support of considering a salaried GP service?

(*Mr Gregory*) Sorry, I thought I had already said that the flexibilities to do so are available and have been available for some time. I do not think that there is a huge enthusiasm for salaried general medical services amongst general practitioners generally and that is reflected in the fact that there has not been a great deal of take up. The General Practices Committee have been much more concerned to establish a much broader basis for dealing with the problems that Mr Llwyd raised than having it go down the salaried GP avenue, although they do not discount that.

167. In our evidence session last week we were told that women GPs were very attracted to the idea of a salaried service and obviously with the large numbers of women who were training at the moment I think that would be a very good move myself.

(*Dr Hall*) Salaried GPs is an option, but to improve the health of some of the communities we are talking about something that will require more than additional doctors, it will require a variety of disciplines in health and social care and other sectors working together and I think that it will be part of the function of the local health group to make sure that the right collection of input and co-ordination of input is available for a particular community, of which salaried GPs might be a component. What we must not forget is we also need community nursing, social care and other social support in these kinds of circumstances.

Chairman

168. The NHS Confederation told us that primary care drug expenditure in the current year was going to rise by £30 million. Can you tell us what the total cost of drug expenditure is at present and what you are doing to contain the cost?

(*Mr Michael*) I will ask Peter to come in on the details, but I think I should make it clear that Putting Patients First set out plans for a unified budget for health authorities so that previously non-cash limited expenditure on prescribed drugs would be included with cash limited health authority allocations for the first time. Previously that budget was held by the Welsh Office and any risk of overspending managed centrally. In future this falls with health authorities. That enables health authorities to spend more effectively according to clinical priorities, that is on drug treatments or secondary care, unfettered by artificial budgetary constraints and savings can be applied to other areas of care. Also, overspend will have to be funded from

[**Chairman** *Cont*]
general cash limits. The issues arising out of that undoubtedly will be a part of looking at the way we have been doing things and the stock take.

(*Mr Gregory*) Could I answer the specific question and that is how much does it cost. The primary care budget is expected to cost in the current financial year around £350 million. We are making very generous provision in the revenue allocations to health authorities that I mentioned earlier for the increase in the drugs bill. The provision we are making is around about the figure that the NHS Confederation have mentioned. The Secretary of State has mentioned what is the key issue here and that is that we are looking in future for unified budgets to provide an incentive which has been missing hitherto and that is for better financial management of the total allocation to the NHS and not just aspects of it. The drugs bill has been a particular problem for us in Wales, not least because rates of prescribing in Wales are higher than they are in England and one of the reasons why the NHS in Wales costs more than England. The measures that we have been putting in place to try and reduce the rate of increase of the drugs budget are having an effect and at the moment the increase is at around about seven to eight per cent, which is one of the lowest rates of increase for the last ten years. That is still a significant increase nonetheless and it requires a lot of money. The provision that we are making to health authorities will be commensurate with our own estimates of what the drug budget increase will be next year.

169. You said that the budget, I take it you mean the drugs budget, was 350 million, is that right?

(*Mr Gregory*) That is the primary care drugs budget. There is also a secondary care drugs budget which is something like another 60 or 70.

170. One of the problems with giving health authorities unified budgets is if they decide to cut down on particular drugs or to have their own policies on drug availability it can lead to anomalies where people in certain parts of the country can get some drugs and people in other parts of the country cannot. Ovarian cancer drugs is a case in point. Do you think that is fair to the patient?

(*Mr Gregory*) I would expect this to be a significant issue for the Assembly. I would have thought that issues around the access of treatment, of which this is one, are issues that the Assembly will want a keen interest in. Most significantly this is about the introduction of new drugs rather than access to well established and tried and tested drugs. Ruth Hall might want to elaborate on that point. There is another point that I would like to make and that is the establishment of the National Institute for Clinical Excellence is going to be of significant value in enabling health authorities to take better informed decisions about the introduction of new drugs in due course. I would hope that would provide a more rational basis for such decisions. I have to say at the same time—this goes to the point you were making, Chairman—on the introduction of local health groups there are issues there about the decisions that they will be taking. As long as they are very well informed decisions, which is what the National Institute is there to help with, we can have greater confidence in decisions that are taken.

(*Dr Hall*) There is very little I can add that would be constructive.

Ms Morgan

171. I agree that it does seem to be mainly an issue with new drugs that the problems arise. As I have got the Velindre Hospital in my constituency where there a number of clinical trials are carried I am very aware that this is an issue that will grow and grow over the next years as more advanced cancer drugs are developed, very expensive cancer drugs, so it is a big issue. What are you doing about the present situation, the Chairman mentioned the ovarian cancer drugs, where they are unequally available at the moment throughout Wales and yet the recommendation is they should be prescribed where the medical practitioner decides it is appropriate?

(*Dr Hall*) My understanding is that there are guidelines for the prescribing of drugs for ovarian cancer and if they are not available I was not aware that was an issue. Certainly we are looking towards equity of access, to treatments which are effective and proven and which are cost-effective. That is the basis on which the National Institute of Clinical Excellence will be operating. It is being formally launched tomorrow. From thereon if there are these kinds of difficulties we will have a national body which is very well placed to assist in that. Furthermore, within the next 12 months we will be having a Commission for Health Improvement which will have a major role in monitoring the implementation of guidelines on the ground. So that will be an opportunity to address some of these very difficult issues. There is for every condition a range of choices available and it is ultimately the clinician's decision as to what is best for that individual patient. I think we must take that into account as well.

172. Absolutely. What the clinician prescribes you have to take into account but I do understand that there are anomalies about treatment of ovarian cancer and I believe Bro Taf Health Authority has said that it cannot afford to pay for taxol. It is a problem, is it not?

(*Mr Michael*) Certainly, particularly if you can give us an indication of the information that has come to you we will have a look at it. It is clearly not something that we are aware of as an issue. It seems a little surprising but it could be looked at.

173. I have written to the Minister about it.

(*Dr Hall*) We would be happy to pick that up.

Mr Livsey

174. If I could raise the whole question of clinical negligence with you. In his recent report on the NHS Wales: Summarised Accounts, the Comptroller & Auditor General highlights the growing costs of clinical negligence claims. In the *Western Mail* on Thursday, 11 March, the health reporter, Alison Watkins, reported the following under a headline which said "Medical Litigation Pay-outs double" and it said: "The National Health Service in Wales is facing a possible £145 million litigation bill as medical negligence claims rise. The size of awards and the spread of claims against the health service

[**Mr Livsey** *Cont*]
during 1997-98 has led to a sharp rise of 78 million according to a National Audit Office report." I wonder if I could ask on the back of that what is your forecast for the cost of claims in future years? Is this going to be a steady rise or is it going to be a vast increase of the kind quoted in that article?

(*Mr Michael*) I think I should explain perhaps that the system that we have is increasing the emphasis on the Welsh Risk Pool to both assess the likely claims for medical negligence and to deal with the finances. Certainly they have increased their estimate and therefore the amount of money that is going into the pool. I certainly would not like to make a forecast on those figures but obviously it is important that risk management is something that is part of the planning of the health service. Certainly we are concerned about the increasing demands on the finances of the health service from two points of view. One is that if there is clinical negligence then that means that people have not received the service that they should be able to expect and, secondly, settlement of claims takes money out of the health service, there is no other way of interpreting it. Essentially our priority is to create an environment which will cut back the increasing demands and the whole Equality strategy, which has been referred to on a number of occasions by each of us, is about making sure that people do get the dependable quality of service of clinical treatment that they should expect. I think it is fair to say that there is something which is not quantifiable which is the extent to which people are increasingly litigious. That is an issue that comes out not only in this but in a variety of other aspects of public life. The Welsh Risk Pool deals with the funding and there is work in hand to widen the scope of statements to all systems and to link an improvement in risk management standards to reduce the chances of clinical negligence cases occurring.

(*Mr Gregory*) Can I just deal with a particular point about the estimate for the future. I think that the headline was slightly less than helpful, not to the Department but actually to public understanding of the issue. You can only get to £145 million if the NHS loses every single claim of which it is currently aware at a prudent estimate of the cost over the next ten to 15 years. The £145 million is actually the most exaggerated figure that you can arrive at, although it is in the C&AG's report. The actual amount of money spent by the NHS in year on clinical negligence claims has been £5 million in 1996-97 and £7 million in 1997-98. I am hesitant about giving you a calculation for this year because I do not actually know what the figure is but I would estimate it at around £9 million or £10 million. If that estimate is wrong I will let the Committee know. What lies behind that is a rising trend in payments for clinical negligence but at still relatively modest levels. Of course two things are happening: one is that the House of Lords' ruling last year has made a significant difference to the quantum of awards being made in successful clinical negligence cases, and secondly the All Wales Risk Pool is actually becoming very much more effective at both understanding the number of claims that are in the system and making prudent provision for them, and I think this is reflected in the C&AG's comments about our handling of this issue. That means that in the C&AG's report for 1997-98 there has been a very significant increase in the contingent liabilities which have been assessed for the future. That is not a function of a massive increase in claims, it is a function of our better appreciation and better management of the whole claims process.

(*Mr Michael*) Or, to put it another way, a change in the system rather than a change in the likely outcomes. Can I just underline the point that Mr Gregory has made. The actual words of the Comptroller and Auditor General were, "I note that significant progress is being made in the effective management of risk within NHS Trusts." I think this is certainly an area in which there has been improvement. The other thing is looking at the level because again that is something that can be open to misinterpretation. The forecast cost of clinical negligence is less than three per cent of NHS turnover. That is a high figure, but the cost reflects cases that have occurred over a period of years and cash being paid out over a period of years and on that basis the calculation of the in-year cash cost to the NHS is nearer to 0.5 per cent. I think we have to be very careful about the way in which figures are interpreted.

175. I understand that, Secretary of State, but I have extracted some figures from the report and the risk pool is going up from £60.1 million to £71.3 for 1997/98/99 and that is an £11 million increase, which by my mental arithmetic is about an 18 per cent increase.

(*Mr Gregory*) Yes, but that is only in the calculation that the risk pool is making of its potential exposure in cases which are not very far advanced.

176. I recognise that and that is why I asked for an explanation.

(*Mr Gregory*) That is what lies behind that and I explained the contingent liability increase which is simple improvements in the way we manage the process and that will also be reflected in the figure you have just quoted. So we have to be careful that we do not confuse improvements in management with what is actually happening in terms of claims made, although I would accept that there is an increase going on.

177. I think there is great concern across Wales about this and obviously it does represent immense human tragedy to the people that are involved. I have got a constituent whose cases cost hundreds of thousands of pounds over nine years. Are you satisfied with the tribunal procedures? It does appear to me that it is almost like them being judge and jury in their own court because the practitioners and professionals are very often involved from both points of view. Would it not be far better if those procedures were truly independent and if they were fair and accountable because there is a feeling of great unfairness and also huge amounts of time expended and money expended on these procedures? Are you going to do something about that?

(*Mr Gregory*) I accept what you said at the beginning of that about the impact on individuals. I understand that some of these cases are extremely distressing and the more so for being protracted. It is incumbent upon us to create a system which is both effective in the way it looks at evidence and looks at

[**Mr Livsey** *Cont*]
the views of people who have suffered and fair and it is a balance that is struck. It is an extremely difficult one to do. As you know, we have completely revamped the NHS complaints process, we have introduced new arrangements both in respect of hospital complaints and primary care complaints and we are undertaking an evaluation. There is a national evaluation of that complaint system going on to see if we cannot improve it and once that evaluation is available I would expect the Assembly to want to look at just the sorts of issues that you have raised, but for the present we have reformed the process in what we regard as effective a way as possible to balance issues of effectiveness and accuracy in the way they go about their business with fairness to all the parties concerned.

178. I think you have described what in general is going on, but you have not addressed the particular, i.e. how is it going to be fairer, how is it going to be better? Have you changed the structure of the enquiries radically or what?

(*Mr Gregory*) As you know, we have introduced an independent element into both hospital and GP complaints processes. I take your point about the protracted nature of this process, but our instinct is in the first instance to see if these matters can be reconciled locally and not go through what is for many people a harrowing and very distressing process. We have tried to put in the new arrangements an emphasis on getting parties to agree about what has happened and what needs to be done in respect of the individual or the system more generally. So we have tried to introduce elements of improvement in terms of the independence and a more rigorous process, part of which is that when we go through to the final stages of this the reports on these individual cases pitch up on to my desk because they are sent to me as the Director and I make sure that any lessons which can be learned from these individual cases are applied. I had one only this week.

Mr Livsey: Thank you very much.

Ms Morgan

179. We have received submissions from SCOVO and Mencap on behalf of 450 people with learning difficulties who are still awaiting re-settlement from long-stay hospitals in Wales, i.e. Llanfrecha Grange, Hensol and Bryn y Neuadd. Is the Welsh Office still committed to care in the community for people with learning difficulties?

(*Mr Michael*) I think the first thing I ought to say is that we are certainly committed to the principle of resettling into the community people with learning difficulties who are living inappropriately in long-stay hospitals and I think that is the way that it needs to be looked at. Resources have been made available to complete the re-settlement programmes at three hospitals in Powys and at Ely hospital. £2 million is being made available over the next two years to support further re-settlement from Hensol and Llanfrechta Grange Hospitals and we have also agreed to support the re-settlement of a further 16 people from Bryn y Neuadd. The intention is for the re-settlement programme to be completed as quickly as the resources allow and clearly this will go on into the period when the Assembly will take responsibility for these issues.

180. Why is the re-settlement taking so long?

(*Mr Michael*) If you are asking the question why has it taken so long then I would have to look to others to answer. You will be aware of the fact that this is a programme which in some ways cases involved considerable numbers of people and it is not only a resource issue, it is also a people issue of getting the placements right.

(*Mr Gregory*) The key difficulty has been the mismatch between the costs of the re-settlement programme and the amounts of money which have been available to fund it. Rather than dealing with this right across the piece so that all hospitals go down at the same rate, the decision was taken to try and accelerate closures in some hospital and, as you know, that has happened in Powys and it has very recently happened in Ely, although there are still some issues about a small number of people and to go for that strategy which would at least give some assurance to people in those hospitals that there was an end date and so on. That inevitably meant that priority had to be given to those hospitals and not to others and I took the personal decision that I should go to North Wales and explain that to the people at Bryn y Neuadd, to the people in the hospital, to their carers, to staff and so on. I did so at a very large meeting we had there because I felt it was important to explain that we were not abandoning them, that we had to take a strategic decision in our judgment and that was what we had done. We recognise that this causes difficulties. I have some of the evidence that has come to this Committee which graphically demonstrates the problem. As the Secretary of State said, we are continuing to be committed to this strategy and we are hopeful that over time we will be able to complete the process of resettlement in the way that he has described.

(*Mr Michael*) I think it is true to say that you will have experiences of cases, as I have, of people being very unsettled by the process and primarily by the uncertainty. In the past you have had programmes that have been set up stretching over many years and, of course, it can take time to work through both the individual's requirements and the correct placement. It can take up to two years to do that process. If you have a decision to take a programme that in itself is going to take many years without absolute certainty that the resources are going to be made available that increases the uncertainty for the individuals, their families, and for the community of the hospital as well. It would certainly be our intention that there is a sensible means of identifying the need, providing the resources, and then working through the process of resettlement as quickly as possible but on the basis of the certainty that the resources are there.

181. I spoke to a meeting of people who were from Ely, mainly from Ely Park Hospital and resettled from Ely, and one of the main concerns they raised was the small number of people who were left in Ely where there are no plans. There may be plans. What is happening for that small number at Ely?

(*Mr Michael*) I think the situation at Ely was that the figure was something like 18 with eight transferred to Hensol, as the resettlement was linked

[Ms Morgan *Cont*]
to a resettlement from Hensol, in other words looking at individuals being resettled as a group. The vast majority will have been resettled by the end of this summer. There is a timescale.

182. There is a target for them.
(*Mr Gregory*) I have had the former general manager of Ely Hospital in to see me recently about this issue in order to impress on him the importance of continuing with this resettlement programme for these last patients. The trust understands that.
(*Mr Michael*) There is also the issue of the resettlement of people who are not going into the community and there are some eight that need specialist treatment. That is a question of resettlement to the appropriate specialist accommodation as distinct from the community. Obviously that has to come into it as the outcome of assessment as well.

183. I would accept it is a huge task carrying this out but there was enormous concern about this small group that seems to have been left behind while everybody else has gone.
(*Mr Gregory*) I can assure you that I have spoken to the general manager and I also spoke to Professor Bill Fraser about it relatively recently to ensure that there is still progress being made.

184. It is different rates for different parts of Wales?
(*Mr Gregory*) Yes. We are trying to make sure that we achieve a good rate of progress of resettlement of all people with a learning disability but that requires the kinds of strategic decisions which I have described and I know that the Department will be looking at the potential for further funding in this process.

185. So the intention is that resettlement will be as soon as possible for wider Wales but you have not got a target date?
(*Mr Michael*) As soon as possible is more practical than a target date, especially when we are talking about decisions that affect individuals. I think it would be unwise to talk in general in terms of dates that might be interpreted in a way that ought to be dealt with at a local level and communicated to the individuals who are involved. We have got to accept that there have been mistakes in the way that this has been done over the years and part of that is to do with some of the deficiencies in management and the relationships between different bodies in the health service which I referred to right at the beginning of my evidence. I think there is a hands-on approach being adopted to try to enable the responsible bodies to work through and conclude this programme.

186. I am going on now to the Congenital Heart Disease Centre at the Heath Hospital. We had evidence last week from representatives from UHW, and this hospital is in my constituency so I am aware of the enormous amount of concern there is about the fact that there is no paediatric cardiac surgery being carried out at the moment in Heath Hospital and indeed nowhere in Wales with children going to Birmingham. It is really about this issue that I want to ask some questions. First of all, are you committed to maintaining a surgical unit within Wales?
(*Mr Michael*) I think the answer to that is yes. I am committed to the re-establishment of paediatric cardiac surgery at the University Hospital of Wales so that children across Mid and South Wales do have better access to this specialist service. I think I have to make the point that it is a matter for the University of Wales NHS Trust, which itself is going through a period of reorganisation, to manage the staffing of individual services but I understand UHW is currently talking to the Bristol Children's Hospital Unit to explore the possibility of a link with them. The establishment of a paediatric intensive care centre in Cardiff with an associated retrieval service was critical to our efforts to save the paediatric cardiac unit. You may be aware that Jon Owen Jones announced additional funding of £1.9 million recurring together with £0.8 million set-up costs to support that. The newly formed Specialised Health Service Commission for Wales proposes to adopt paediatric cardiac services and paediatric intensive care as part of its remit and that will draw up a specification for what should be provided.
(*Dr Hall*) It certainly is a matter of very great regret that the consultant surgeon left to take up a prestigious post in Italy, in fact, and every effort is being made to reconstitute the service because it is recognised that in any service which involves children access, and ready access for families, is one of the most critically important factors. In fact, access to families is part of the process of managing and healing in the recovery of children. Nevertheless, there is an issue about ensuring that quality is sustained and taking into account the advice of the Royal Colleges. We are, therefore, in an interim situation at the moment where a first class service is being offered by Birmingham to cover the gap whilst recruitment efforts are being made by the University of Wales Hospital Trust. As the Secretary of State has already said, it has been indicated by the Royal Colleges involved that a link with Bristol might facilitate both recruitment and provide a training base of sufficient calibre to take this service forward into the future. I have to say that the service offered in Cardiff was recognised both nationally and internationally as quite outstanding and in that respect we have to be deeply sorry that we lost the key person to that service. Every effort is being made to reinstate it and to take it forward in a way that will be attractive to others and will facilitate the attraction of a top flight surgeon to run it.

187. I think the Committee were very dismayed by the evidence that we were given last week, particularly about the reasons why the first class paediatric surgeon left, because one of the reasons given was the fact that the number of adult operations that were being done at the Heath Hospital were actually significantly reduced to 800 and he was personally very frustrated at not being able to carry on developing in the way that had been done before. I am sure this was a decision made by the previous administration. I wonder if Mr Gregory can cast light on this decision which divided the service between Morriston and UHW, which I do not think anybody was expressing any concern about but the fact is that the number of operations at Heath actually went down as a consequence and we did lose our top flight surgeon. Can you comment on that?

[**Ms Morgan** *Cont*]

(*Mr Gregory*) Perhaps I can just say that both Dr Hall and I had conversations with Mr Musumeci before he left so I do not think either of us was left in any doubt about why he was leaving. Nor did we allow it to happen without seeking to—prevent is the wrong word—convince him that he should stay. I have to say also that over a long period of time the Department has strained every sinew to set this unit up which was not itself a very easy task to convince all the key stakeholders, including the Royal College, that this was a good idea. We set it up and it surpassed everyone's expectations and as a consequence we were deeply disappointed at what happened. I think there is a connection with the adult situation. In the early 1990s, of course, there were only about 600 coronary heart bypass operations being done and it was clear that that was wholly inadequate and a decision was made to raise it to 1,400. The decision to go to 2 centres was taken by the last administration, but associated with it was an understanding that whilst UHW, which had increased its capacity to something over 1,000, should continue to do that whilst Morriston came up to speed, the intention was always to drop back to the 1,400 target and that is what has happened. That was not popular in UHW amongst clinicians, perhaps they have made representations to you as they have to us and that was a decision which was confirmed by the Department but taken by the NHS and we are now looking to see, along with the NHS, whether over a period of time the number of adult operations can be raised still further. It had always been expected that this change would happen, but there were frustrations about it amongst the clinicians. I think there is another element in the story about the ambitions of UHW to undertake other kinds of heart operations, including transplantation. Other than having described the process that was gone through, I do not think I can add very much more to the subject.

188. It just seems an absolute tragedy that this has happened and we do not have the cardiac surgery going on in Wales at the moment. I know that they told us last week that there was a request in to raise the number of adult operations at the moment. Is that likely to be successful?

(*Mr Gregory*) The Specialist Health Services Commissioning Group the Secretary of State described earlier is going to give us advice on that and once we have got their advice and once we have looked at the financial and clinical implications of it the Department is going to be able to give a decision on that.

189. So you are not in a position to say at the moment?

(*Mr Gregory*) No.

190. I think that is one of the things that would help the situation. Dr Hall said about the Royal College of Surgeons and their advice. Do you think the Royal College of Surgeons is right to insist that Cardiff forms a joint unit with Bristol?

(*Dr Hall*) There is a trend nationally to consolidate expertise across what I think are 17 centres and it is the Royal Colleges' view that that kind of basis would give an appropriate body of expertise to support training which is required at a supra specialist level. This is a specialty which attracts only a very small number of individuals on a worldwide basis and therefore we are looking at trying to provide a focus to give that level of expertise. That is the College's view and they will have come to that view on the basis of evidence and a considerable amount of work and I think is a view that we should respect.

191. I understand from the evidence we received last week that it is actually very difficult to get a meeting with the people involved in Bristol, because of all the problems with the Bristol Inquiry which has started up, to take forward these proposals and I think it is a sort of chicken and egg situation because they will not be able to get a surgeon in until something is sorted out with Bristol on the advice of the Royal College of Surgeons, so it did seem a bit of an impasse. Can you help in any way?

(*Dr Hall*) I was not aware of that particular difficulty and, indeed, I think that this is an issue which does need urgent and prompt attention and I would be pleased to try to facilitate that.

192. We were told last week that it was not possible to get even a meeting going. Does it not seem deeply ironic that where we had a first class service in Wales, with outstanding and wonderful results, there is now nothing in Wales, but Bristol, where they had enormous problems, is now operating a good service and we have not got anything?

(*Dr Hall*) At the end of the day we want the best possible outcome for the children and the individuals who need care and that is certainly something that I think within Wales we would wish to strive for.

(*Mr Gregory*) One of the lessons to be learned is that having a unit like the one in Cardiff, which is as vulnerable as it was because of its size and because of the size of the clinical staff, is something that we need to avoid for the future, if we can and the message the Royal College is sending us is that we need to find sensible and effective ways of doing that.

193. I suppose we need to learn the lesson that when we plan services we take into account the issues of what people who are operating in such a tremendous way do.

(*Dr Hall*) I am sure the specialist services will be doing just that.

194. Do you think it is important that we have paediatric cardiac surgery in Wales?

(*Mr Michael*) Yes. That is why we are committed to having that service. I think this is another of those areas we were mentioning earlier where you have got to recognise that if you have not got a number of individuals with a high level of expertise then the service is vulnerable to the movement of one individual. That issue is tied in with the ones that Ruth Hall was mentioning of making sure that you have got the cover and the level of high expertise in terms of supervision and development and training and critical mass and experience. Clearly what we always have to be thinking about (and these are issues that it is difficult for us as lay people to make a judgment about) is where it is appropriate to make sure that the service is available in Wales rather than something that is perhaps available only in one or two places in the United Kingdom. There are judgments to be made there because obviously it

[**Ms Morgan** *Cont*]
means that there are resources committed as well as a degree of vulnerability, which is one of the lessons that comes out of this particular sequence of events.

Mr Llwyd

195. I understand that the University of Wales Hospital Trust is to commence this Thursday without a chief executive and that the previous chief executive at the Heath and the gentleman at Llandough, who were not appointed, were made redundant and I understand from the press that there will be a pay off of £¼ million. Is that not a highly undesirable position? Key appointments are not being made now because of the void at the top and to adopt the Secretary of State's analogy from earlier on, this is clearly a ship without a captain on the bridge. Let us all hope there are not too many large icebergs out there.

(*Mr Michael*) There is an acting chief executive in place. I have got great confidence in the chair of the combined trust which brings together Llandough hospital and community trust and the UHW trust and I am also confident that we are going in the right direction by creating a single health service for the Vale of Glamorgan area. I am not sure that it is appropriate to comment on the individual appointments. It would have been preferable to have a chief executive in post at the point of the creation of the new NHS trust, but in the longer term it is very important to make sure that we have the right management and the right structure of trusts. Certainly it has taken a little time to come to the conclusions about where we are going because I referred earlier to the fact that when I arrived in office there were proposals on which consultations had taken place and there were clearly problems with some of the outcomes, which is why we went to a second consultation which, incidently, received a very favourable response but means that we are doing the right thing in a much shorter timescale and I think that is one of the issues that has led to the difficulties of establishing the new trust in quite the way that we would have desired, but I am quite sure that we are going in the right direction and that we will have stability and an integrated Health Service for the Cardiff and Vale of Glamorgan area once these difficulties have been worked through.

Chairman

196. I would like to ask about the Talygarn Rehabilitation Centre. We have had a lot of representations from some Members of this House about its proposed closure. Firstly, when do you expect to come to a decision on this and why has it taken so long?

(*Mr Michael*) Can I say that the matter has been referred to me for a decision and that means, as I have a quasi-judicial role, I have to be very careful not to go beyond what it is appropriate to say. It is a matter that is under consideration at the moment. I certainly do not want to delay the decision unduly but there are a number of complex legal and health issues involved. You may be aware that one of the parties with an interest in the centre, which is the Coal Industry Social Welfare Organisation, instigated legal proceedings against the then Secretary of State when it was last before him for decision in 1992 which demonstrates the fact that it is a complex issue and there are legal considerations as well as health ones. The fact that took place on a previous occasion is not material to the decision but it does indicate some of the complexity.

197. It probably indicates the strength of feeling about the closure as well, does it not? Can you assure us that the closure will not be approved? I realise you are in a quasi-judicial position on this but it would be nice to have an assurance that you are satisfied that the services that Talygarn provides will be fully replaced elsewhere in Wales before you make a decision to close it.

(*Mr Michael*) Can I say that it is clearly important that any community which is affected by a proposed closure, if I put it in general terms rather than the specific, understands the nature of the service that is going to replace the one that is being withdrawn. It is a point that I have made very strongly in all of the discussions that I have had, that confidence has been undermined if you look at things like the closure of St David's Hospital in Cardiff and the long period of time where the promised replacement has not emerged. Part of the consideration in the stock take is to make sure that we get processes in place which allow us to take important strategic decisions without local communities thinking that everything which involves a closure in order to provide a more modern service inevitably means losing service and things becoming more distant or more services disappearing completely. At the moment there is not the confidence amongst the public or within the health service about the strategic decision making that has gone on over recent years. People are not prepared to take it on trust that things are changing. Therefore, we have to build new trust, which is what both of the building and replacing the levels of management within the Welsh Office in preparation for the arrival of the Assembly are about, it is what the stock take is about, and it is what the reconfiguration and the attempt to build new relationships between the health service bodies is about. It is also what creating a new configuration of community health councils is about so that the voice of local communities can be heard because very often early decisions in which proposals are fully debated and understood gives a chance of individuals responding positively. If they are not just told "you are going to lose something" but "this is what you are going to get in place" and there is a confidence that it is going to improve the services to the communities and to the patients then people will by and large go along. They may be reluctant to see something to which they have been attached over many years disappear but many people will recognise that there needs to be change in order to improve services, improve clinical practices and to become more up to date. What people fear is that modernisation is simply a title that covers up straight forward cuts. I say that in general terms rather than on this specific one for the reason I mentioned when you first asked about this unit. I think that in any circumstances where a decision comes to me to be resolved I would

[**Chairman** *Cont*]
certainly be looking to be assured about the service provision that would follow that decision whether it was a yes or a no.

198. Can I just add to that because one of the pieces of evidence we have had is that there are particular diseases that Talygarn treated, one of them being ankylosing spondylitis, and there is not a facility elsewhere for that type of treatment. I do not want to go on at length about this but it may be worth revisiting that particular topic unless you have anything you particularly want to add.

(*Mr Gregory*) I do not think we can. We know the point you are making and it is covered in the submissions that have been made to us. On the issue of delay, we have not been delaying, there was a difficulty at the outset in our consideration of these issues because we were not provided with all of the information that we needed and it was the retrieval of that that has slightly held us back. We are at a reasonably well advanced stage in providing information to the Secretary of State.

Mr Llwyd

199. Just one or two closing remarks, if I may, as far as I am concerned anyway. Can I take you back to the question of pay awards. May I ask is it possible to have a written response to these three short questions that I would like to put.

(*Mr Michael*) Let us hear the questions then.

200. You can always answer no of course.

(*Mr Michael*) I was going to generously answer yes before hearing them, but on second thoughts.

201. It is inclusive. The first one I would like to put is what is the present overall NHS pay bill in Wales? Secondly, of the £175 million identified earlier today, what would be left of that money after meeting the pay awards in full? Thirdly, and this may be difficult, I do not know, could anyone comment on why laboratory technicians and path lab workers and the like have been offered such poor pay awards?

(*Mr Gregory*) Sorry, could you repeat that?

202. It may be difficult for you to comment—I might be shooting in the wrong direction, it will not be the first time—but why have laboratory technicians, pathology laboratory workers and others received such very poor pay awards? This may be difficult for you to comment on but I would be grateful if you have any information on that.

(*Mr Michael*) Obviously we will respond as fully as we can to those questions but in some of them there is a question over like for like because there is a change in the employment from one year to the next in terms of the actual pay bill as distinct from the increase on estimates. I think certainly it would be possible for us to give indicative figures. On the last one, because I am unsighted on that, that is one of the professions ancillary to medicine, are you saying that it is being treated differently from other ancillary professions as distinct from, for instance, doctors and nurses?

203. That is my understanding, that they are not covered by the overall settlement.

(*Mr Gregory*) Because they are in a different professional group.

204. And they are not being accorded the same level of pay rise, is that right?

(*Mr Gregory*) It is part of a national agreement. I think we ought to give a written answer but I think the answer is going to say that is because of the outcome of national negotiations.

(*Mr Michael*) We can be clear about the specific points. The answer is yes, we will answer your questions.[2]

205. My answer is thank you.

(*Mr Michael*) In as full and friendly a way as we can.

Chairman

206. Thank you very much, Secretary of State, we look forward to getting those answers in due course. Thank you for coming today and I am sorry about the James Bond movie on the Thames.

(*Mr Michael*) Can I thank the Committee for the hearing. I do think that the NHS is going through a period of change where it is important for people to understand the nature of the change that we are trying to bring about. That is sometimes difficult to achieve because, as has been indicated by these discussions, there is a series of complex issues to be dealt with, management, financial, clinical and community issues. I do believe that we are on the way to giving the sort of stability in the health service that both staff and the wider community have a right to expect.

Chairman: I am sure that will be very welcome. Thank you.

[2] See Evidence page 62.

WRITTEN EVIDENCE

1. Memorandum submitted by the NHS Confederation in Wales

KEY ISSUES FACING THE NHS IN WALES

The NHS Confederation in Wales

The NHS Confederation in Wales (hereafter the Confederation) is a territorial branch of the UK-wide NHS Confederation; the latter body was established in 1997 by the coming together of the National Association of Health Authorities and Trusts, and the NHS Trust Federation. It represents the interests of NHS management bodies across the United Kingdom. Its principal concern is to promote the NHS to policy decision makers, media and the wider health community. All Health Authorities and NHS Trusts in Wales are currently members of the Confederation.

The Confederation recognizes that the National Assembly will bring fundamental change to relationships in the NHS in Wales. The service is committed to working under the leadership of the National Assembly to ensure that the service is "fit for purpose" for the millennium.

Setting the Scene

The NHS is anticipated to spend £2.4 billion of resources in 1998–99; the health service is the second largest part of the Welsh Block.

The NHS also makes a significant contribution to the Welsh economy. The Welsh NHS:

- directly employs 60,000 staff (7.2 per cent of the working population), and contributes indirectly to employment in other sectors;
- provides a large market for goods and services;
- promotes research and development on a large scale;
- is responsible for meeting the healthcare needs of the Welsh workforce.

The Welsh Health Service is facing many major challenges. The response to these will set the direction and pattern of healthcare services for the next century, in which the National Assembly will have a pivotal role.

The Service in Wales is currently going through major organizational change, arising from:

- The creation of the National Assembly.
- *The All Wales Service Review* commissioned by the five Health Authorities of Wales. The purpose of the Review was to understand how the various component parts of NHS Wales inter-relate, define health needs, determine the utilisation and efficiency of existing services and to raise questions about whether the money provided by Government is spent to the best effect to meet the diverse needs of the people of Wales. The Review, published in December 1997, concluded that, unless hard choices were made, the Welsh NHS would continue to have an increasing deficit year-on-year. A number of key issues for the service were identified and these are summarised in the Executive Summary, a copy of which is attached (*Not printed*).
- The White Paper—*"Putting Patients First"*, which includes the abolition of the Internal Market in healthcare and GP Fundholding, the establishment of Local Health Groups, the Reconfiguration of NHS Trusts, the replacement of contracting with Long Term Agreements, the development of Health Improvement Programmes and the development of the Quality Agenda covering Quality Care and Clinical Excellence.
- The Green Paper—*"Better Health, Better Wales"*, which addresses public health matters and takes the NHS into the "broader health agenda".

The delivery of this challenging agenda is compounded by:

- the growing financial deficit faced by many of the Trusts and Health Authorities in Wales;
- the unprecedented demands created by the ever increasing emergency admissions (15 per cent increase between 1996 and 1998) and pressures on critical care beds;
- the waiting lists reduction targets that the Service has been set;
- the need to absorb the implementation of legislation and policy directives, for example—crime and disorder legislation and establishment of youth offending teams;
- the need to absorb the cost pressures discussed later in the paper.

All of this is placing the whole Health Service in Wales under considerable pressure, at a time when the service is going through further, major structural changes as follows:

- on 1 April 1996, the number of Health Authorities was altered from 17 to five;
- on 1 April 1999, the reconfiguration of NHS Trusts will lead to a reduction of NHS Trusts from 26 to 16;
- GP Fundholding will end on 31 March 1999;
- Local Health Groups are being established on 1 April 1999.

Change on this scale takes time to work through; the NHS now needs a period of stability to ensure that the benefits of all these changes are realised and that the agenda for health services is delivered. This must be done also at a time when management costs are being significantly reduced, and there is a great deal of managerial turbulence. It will be extremely challenging for those leading and managing the service.

Key Issues

There are seven main areas that the NHS Confederation wishes to bring to the attention of the Welsh Affairs Committee:

- The Broader Health Agenda
- A Responsive Service
- Emergency Admissions
- Shaping the Service for the Millennium
- Working in Partnership
- Staff Recruitment and Retention
- Resourcing the NHS

The Broader Health Agenda

The Confederation in Wales supports the drive towards reducing health inequalities and improving health status and looks forward to playing a full part in achieving the broader health agenda outlined in "Better Health—Better Wales".

NHS Wales has considerable public health expertise and experience and public health professionals will make a major contribution to the broader health debate. The Confederation welcomes the setting up of the Welsh Centre for Public Health and will offer full support to make sure it succeeds.

The Confederation recognizes that the health service contribution to health improvement needs to be made in partnership with other agencies, groups and communities, and that local government has a lead role in promoting health gain as a central feature of all public services.

The Welsh NHS is working closely with the Welsh Local Government Association on joint issues, such as the development of Health Improvement Programmes (NHS lead) and how this work will connect with the setting up of Health Alliances (local government lead).

The NHS Confederation in Wales is also fully supportive of the Health Gain Targets which were announced by the Secretary of State in June 1997. These include two public health issues that would benefit from early attention on the part of the National Assembly:

- a reduction in smoking levels;
- fluoridation, which is a major opportunity to improve dental health in Wales, and which would save NHS Wales £50 million a year.

A Responsive Service

The NHS in Wales is committed to improving the way it responds to changing patient needs and is keen to work with the National Assembly on developing ways of assessing performance. The Welsh health service recognizes that it is important to demonstrate that resources allocated are used in a cost-effective and efficient way to meet patient needs.

The Confederation welcomes the emphasis of higher quality services and its member organizations will ensure that the service responds to the new provisions of clinical governance.

The National Institute for Clinical Excellence and the Commission for Health Improvement will report to the National Assembly in respect of health services in Wales, and the Confederation is keen to ensure the full involvement of the service.

The Confederation is interested particularly in taking a fresh look at the approach to people waiting for treatment. It is suggested that the time people wait for treatment is a more appropriate performance indicator, rather than the numbers of people on a waiting list. It is important also to take clinical priorities into account when determining waiting times, so that those in greatest need receive quicker treatment.

Finally, it is not just doctors who are involved in managing waiting times. Nurses, physiotherapists, speech therapists and other professions can all play their part. The service will look to the Assembly to encourage a new approach to the way professions other than medicine can be involved in keeping waiting times down.

Emergency Admissions

Members of the Welsh Affairs Committee will be aware of the significant increase in emergency admissions to hospitals in Wales over recent years. This trend is continuing and whereas the increased admissions were originally confined to the winter months, in recent years the increases are seen over the 12 months of each year. Annex 1 shows the number of Emergency Admissions to Welsh Hospitals between April and December for each of the last three years. The worrying factor is that admissions for December 1998 and January 1999 have seen further significant increases.

The Confederation welcomes the £11.5 million made available by Mr Jon Owen Jones for this winter, yet it is clear that its non-recurring nature and late release meant that its use was constrained. There is a clear need for such funding to be made on a recurring basis and at an early stage in the financial year, to enable optimum use to be made of it.

The NHS faces a specific issue over the next winter, in the form of the Millennium, and the potential impact on the service. The ability of the NHS to maintain emergency services during the period from 24 December 1999 to 3 January 2000 will depend on:

— the availability of NHS staff;

— the reliability of equipment;

— the availability of social services provision to ensure that people are not admitted to hospital inappropriately, and that people can be discharged promptly;

— access to primary care services, to prevent inappropriate use of hospital facilities;

— availability of both emergency and non-emergency ambulance transport services.

The Welsh Office Health Department and NHS in Wales have set up an All-Wales Steering Group to ensure that the service identifies all the issues and the solutions needed; the NHS participates also in the High Level Inter Agency Forum chaired by the Secretary of State for Wales and it is important to recognize that the public sector as a whole needs to be prepared for the impact of the Y2000 and to be involved in the planning to ensure service continuity.

Shaping the Service for the Millennium

The All Wales Service Review has been referred to earlier in this submission. It was clear to the five health authorities that, even if there were no financial pressures, the Welsh health service needed to make substantial changes. The need for change stems from:

— continuing changes in clinical practice;

— ongoing technological developments;

— national policy imperatives, such as those resulting from the implementation of the Calman Hine Cancer Service Report and the forthcoming development of National Services Frameworks;

— the joint commissioning agenda being developed with local government.

Indeed, the Labour government has set itself the task of modernising the NHS, through investing in NHS staff, buildings, equipment and information systems. There is a clear need in the NHS in Wales to:

— develop new services in appropriate settings. This will need the closure of some old and expensive buildings;

— replace old and existing buildings;

— strengthen further primary care services;

— remodel hospital services;

— work with local government to review care in the community, particularly for elderly people.

The National Assembly will lead the debate on the future direction of the NHS in Wales and the members of the Confederation are committed to participating fully in that debate.

Working in Partnership

The NHS in Wales is committed to working with others, under the leadership of the National Assembly, to ensure the smooth delivery of health and social care services. The Health Authorities particularly look forward to strengthening the working relationship with local government and the five authorities are reviewing the opportunities for involving elected members in the work of the NHS. The health service will take the lead on health improvement programmes and will ensure that all partners are engaged fully as the work develops. It will be important particularly to involve local government partners, in view of their lead role for setting up "health alliances".

The Health Authorities of Wales, and the WLGA hope shortly to conclude a formal memorandum of understanding, setting out the approach to partnership working. A work programme will follow to take forward the joint commissioning/working agenda. This will include:

— clarifying roles and contributions to the broader health agenda;

— clarifying roles and contributions to Crime and Disorder legislation;

— introducing a new focus on health determinants by implementing close working between health and local authority professionals;

— reviewing existing IT, data and surveillance systems with a view to developing a common data base and networks.

Staff Recruitment and Retention

Some parts of Wales are experiencing difficulties in recruiting and retaining certain grades of staff.

The situation on nurse recruitment in Wales is not as severe as the apparent position in England. However, there are difficulties in some areas in recruiting specialist nurses, particularly in Operating Theatres, Critical Care departments and Paediatric Nurses. The Confederation welcomes the recent Government announcement on the national recruitment campaign and on improving nurses pay, although it considers that the pay award must be fully funded. The Confederation also supports, in principle, the Government's plans for pay reforms and the wider NHS Pay Agenda.

Some of the Health Authorities in Wales are experiencing difficulties in recruiting General Practitioners, particularly in the Valleys and parts of rural Wales. Approximately 20 per cent of GPs are due to retire in the next five years and this will add to recruitment difficulties.

Resourcing the NHS

Members of the NHS Confederation in Wales recognise the priority that the Government is giving to the health service and understand the many competing pressures for public funds.

The Confederation welcomed the outcome of the Comprehensive Spending Review consultation process and the Secretary of State's decision to provide an additional £175 million for NHS Wales in 1999–2000, increasing to £510 million recurring over a three year period.

The Confederation acknowledges that spending per head on health and personal social services is higher than in England; the reasons for this are well-documented and include:

— higher crude death rates;

— higher self reporting of long term limiting illness;

— more people aged 75+;

— higher levels of elderly people living alone.

In 1998–99, Health Authorities were allocated £1,862 million in cash limited revenue monies and voted £389 million in non cash limited resources. Capital monies to the value of £97 million was made available to NHS Trusts in Wales. Based on latest estimates, the in-year deficit is some £20 million, which, taken with previous deficits, results in some £54 million of accumulated debt. We referred earlier to the projection that, unless hard choices are made, this debt will rise significantly in future years.

The NHS faces significant cost pressures in the coming year:

— inflation costs on Hospital and Community Health Services will be at least 5 per cent, including the impact of wage awards at some £80 million;

— workforce change issues, including reducing the working hours of junior doctors and discretionary points schemes, require £7 to £10 million;

— the NHS in Wales needs an extra £15 million each year to keep up with advances in technology and new drug therapies;

— primary care drug expenditure will be £30 million above 1998–99 levels;

— the NHS will spend around £10 million in 1998–99 on medical negligence claims. Costs are rising by £3-5m each year, with the managers of the Welsh Risk Pool suggesting that £13 million-£15 million will be needed in 1999–2000;

— there is an increase of £5 million-£6 million in the costs of Welsh blood products, mainly as a result of changes needed to blood filtering as a consequence of the potential risk of new variant CJD;

— the monies provided to Welsh health authorities in 1998–99 to reduce waiting lists—some £18 million—needs to be recurring, to enable the service to sustain waiting list reduction;

— the NHS received an additional £11.5 million in 1998–99 to cope with winter pressures. This funding needs to be provided on a recurring basis to meet the demands referred to elsewhere in this

submission; 20 per cent of this funding was made available to social service colleagues, and without this support there will be increased social care pressures;

— complying with statutory requirements including health and safety regulations and child protection is placing increasing financial strain on NHS Trusts.

In addition to the cost pressure associated with existing services, the NHS in Wales faces the need to make significant additional investment in moving the service agenda forward—investment is required in such key areas as mental health, adult and children's critical care, cancer services and primary care improvements. Even limiting the investment to one per cent to two per cent per annum calls for additional resource of between £15 million-£30 million.

The NHS needs access to additional capital monies, both to maintain existing stock and to invest in the new facilities needed for modern healthcare delivery.

New additional costs will be incurred by the NHS each year that require funding from the resources set aside in future years, eg the employer's pension contribution will increase by 3 per cent to 7 per cent from April 2001 at an estimated additional cost of £35 million for the NHS in Wales. It is important that this, and other costs, are fully recognised in the allocations made each year.

Key Messages

The NHS welcomes the opportunity to work under the leadership of the National Assembly, to review quality of health care services and to agree the performance measures against which to assess NHS performance.

The NHS Confederation considers that one such measure should be waiting times not lists.

Even without the financial pressures on the service, the NHS needs to change to provide a service fit for the 21st century:

— new services need to be developed in appropriate settings; this means that some old and expensive buildings need to close

— primary care need further strengthening;

— hospital services need remodelling;

— services for elderly people need reviewing.

The financial pressures are so severe that the NHS faces substantial increasing year on year deficits unless hard choices are made.

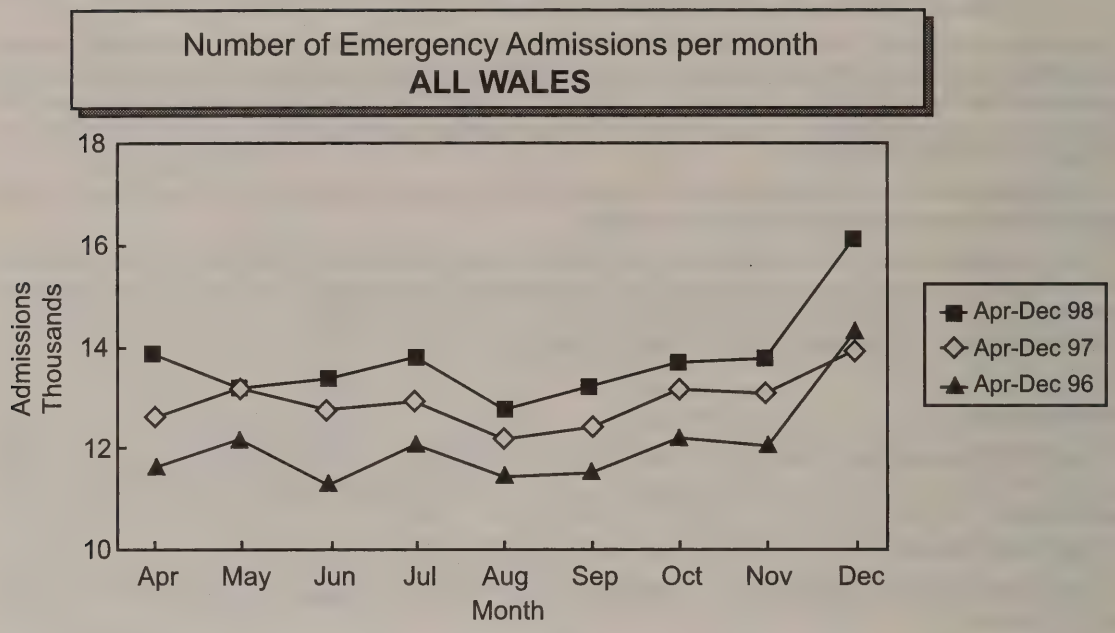
The NHS has been through significant change recently and now needs a period of stability to let all the changes work through.

Phil Davies
Director

18 March 1999

Annex 1

GLAN HAFREN NHS TRUST



EMERGENCY ADMISSIONS

	Apr-Dec 98	*Apr-Dec 97*	*Apr-Dec 96*
Glan Hafren	15,350	14,167	13,917
Nevill Hall	4,796	4,924	4,058
UHW	12,936	12,618	11,795
Llandough	9,835	9,421	9,039
North Glam	6,892	5,622	5,414
East Glam	6,158	6,002	5,725
Bridgend	6,190	5,706	5,090
Morriston	6,847	5,981	5,850
Swansea	12,960	11,980	9,610
Glan-y-Môr	4,251	4,080	3,472
Carmarthen	3,738	3,632	3,518
Llanelli	4,469	4,150	3,914
Ceredigion	2,984	2,850	2,896
Pembroke	3,859	3,938	3,745
Wrexham	6,594	6,304	6,026
Gwynedd	8,166	7,874	7,932
Glan Clwyd	7,310	6,700	6,105
All Wales Total	**123,335**	**115,949**	**108,106**

2. Memorandum submitted by Dr Richard Kirk, Welsh Congenital Heart Disease Centre

PAEDIATRIC CARDIAC SERVICES

SUMMARY

I. The Congenital Heart Disease Centre was established in 1991 after a prolonged campaign to provide a local Welsh service. It provides comprehensive care for the fetus, child and adult with congenital cardiac disease and support for many other clinical services eg fetal medicine, neonatology and paediatric intensive care.

II. The Centre has always been open to outside assessment and its excellent results have been regularly communicated to Purchasers and Clinicians.

III. The paediatric cardiac surgeon resigned in August 1998 to take up a prestigious post in Rome. Attempts to replace him have so far been unsuccessful. Since September 1998 the Welsh Congenital Heart Disease Centre has therefore been unable to provide a local surgical service although the local cardiological service has been maintained.

IV. An alliance has been formed with Birmingham Children's Hospital enabling surgical procedures (emergency and routine) to be undertaken in Birmingham, ensuring the safe re-establishment of the local surgical service and compliance with clinical governance.

V. There is strong support for the continuation of the service from the Welsh Office, Health Authorities, Paediatricians and Patients. Re-establishing the surgical service and taking the opportunity to restructure will provide an improved service and enhance patient choice. In addition it will allow the continuation of comprehensive fetal medicine, neonatal and Grown Up Congenital Heart Services and the development of Level 3 Paediatric Intensive Care and Retrieval Services for Wales.

VI. Recruitment of a Paediatric Cardiac Surgeon has proved difficult for several reasons including a lack of UK trainees and registration problems for overseas applicants. In addition the Royal College of Surgeons of London support for the re-establishment of the surgical service is now conditional upon the Congenital Heart Disease Centre joining forces with the Bristol Unit. Negotiations have begun with the Bristol Children's Heart Unit to explore this option.

VII. The Congenital Heart Disease Centre has now been without a surgical service for seven months. If the current situation continues, it is inevitable that key staff will leave, skills will be lost in those who remain, recruitment will become extremely difficult and Purchaser confidence in the service will be lost. The Centre is therefore working hard to ensure that the links with Bristol are established, to enable it to move forward.

1. BACKGROUND—DELIVERY OF UK CONGENITAL HEART DISEASE SERVICES

1.1 The core work involves the diagnosis and treatment of children (0–16 years of age) but a substantial proportion of the work managing the fetus and adult with congenital heart disease.

1.2 Outpatient work involves the diagnosis and non-invasive treatment of cardiac disease. There is a heavy commitment to outreach clinics throughout South Wales.

1.3 Inpatient treatment comprises the emergency management of extremely sick patients (usually babies) and the elective investigation and invasive (surgical) treatment of patients with more stable cardiac disease.

1.4 Many of the skills of the staff (medical and nursing) in the cardiac units are required in the management of ill babies and children without cardiac disease—particularly in life threatening situations.

1.5 There are 17 Paediatric Cardiac Units in the UK with activity levels and staffing dependent upon their referral population and capacity to undertake overseas work.

1.6 To maintain "cutting edge" cardiological expertise it is generally accepted that a surgical programme should be present on-site. This allows proper professional development and the full range of cardiological activities eg interventional catheterisation to be performed.

1.7 There has always been a debate as to the optimum number of Units in the UK required to balance local access to a service with activity levels sufficient to maintain staff skills. There is no evidence from the UK data that activity levels correlate with clinical outcomes.

1.8 A further debate exists as to the optimum number of operations a surgeon should perform and whether they should work solely with congenital heart disease or have a mixed adult and paediatric practice. 80 per cent of surgeons in the UK have a mixed practice and undertake an average of 120 paediatric operations per annum. Data from the Society of Cardiothoracic Surgeons of Great Britain and Ireland and a recent national study co-ordinated by Great Ormond Street Hospital does not demonstrate any relationship between clinical outcome and the number of procedures a surgeon undertakes.

2. The Welsh Congenital Heart Disease Centre

2.1 The Welsh Congenital Heart Disease Centre was established in 1991 after a prolonged public and professional campaign to provide a local Welsh service. There are 3,500 outpatients and 400 inpatients, of which 120 require a surgical procedure, treated per annum. In addition the service is an integral part of the regional fetal medicine service (Fetal Cardiac Service), the adult service (Grown Up Congenital Heart), the Regional Neonatal and Paediatric Intensive Care Services, and the undergraduate and postgraduate training programmes for medical and nursing students, technical staff, nurses and doctors.

2.2 The Centre has always practised evidence based medicine, consistently assessed its results, been open to outside assessment (Welsh Office Post-Implementation Review, Bro Taf Review, British Cardiac Society Peer Review) and informed families, in writing, of individual risks of a procedure. The Centre's surgical results have been recognised by the College of Surgeons of London to be "excellent, comparing extremely favourably with the best centres not only in the UK but worldwide". Purchasers and Clinicians have received regular information regarding overall results and those relating to specific procedures.

2.3 Mr Musumeci was the principal paediatric cardiac surgeon. In 1998 an approach was made by the Saint Camillo Cardiac Centre in Rome to secure his services and despite attempts by the Trust to retain him, Mr Musumeci resigned with effect from 31 August 1998.

2.4 To date attempts to replace Mr Musumeci have been unsuccessful and since September 1998 the Welsh Congenital Heart Disease Centre has been unable to provide a local surgical service. Surgical procedures (emergency and routine) have been undertaken in the Birmingham Children's Hospital.

2.5 The facilities and staff of the Congenital Heart Disease Centre have however continued to function with cardiological assessment and non-invasive treatment provided within Wales. The spare capacity on the Paediatric Cardiac Ward has been managed by caring for children with renal disease whilst the Paediatric Cardiac Intensive Care Unit staff now manage all children requiring intensive care. The delays in re-providing a surgical service are however severely affecting staff morale and purchaser confidence in the continuance of the service and there is considerable concern that critical staff may leave.

3. Justification for Continuance and Consequences for its Demise

3.1 Re-establishing the surgical service and taking the opportunity to restructure will provide an improved service and enhance patient choice. It will allow the comprehensive fetal medicine, neonatal service and Grown Up Congenital Heart Disease service to continue and the Level 3 Paediatric Intensive Care and Retrieval Services to develop and ensure that Wales meets the UK National guidelines.

3.2 Support for the continuance of the Congenital Heart Disease Centre with a surgical service has been overwhelming and includes the Welsh Office, Health Authorities and Trust, the Chief Medical Officer for Wales, the Directors of Public Health Medicine, the British Paediatric Cardiac Association, Specialist Advisory Committee for Paediatric Cardiology Training, the District General Hospital Paediatricians, the Welsh Paediatric Society, Patients and their Families.

3.3 A surgical programme is essential if Wales is to recruit and retain staff capable of providing a high quality cardiology, anaesthetic and intensive care programme.

Failure to re-establish the surgical programme would therefore affect the:

- Development of the eight-bedded General Paediatric Intensive Care Unit and Retrieval Service and thus compromise the delivery of Level 3 Intensive Care in Wales.
- Fetal Medicine Service for Wales that refers patients with suspected cardiac disease and its loss would thus compromise the fetal screening and treatment programme.
- Neonatal service as premature babies often require cardiac assessment and 25 per cent of babies with a structural anomaly have an associated cardiac condition. The demise of the Centre would require many seriously ill babies to be transferred out of Wales for cardiac assessment despite the fact that otherwise their treatment could have been expertly managed within Wales.
- Grown Up Congenital Heart Disease Service without congenital heart disease surgery would lack the staff skills to continue to provide a service.
- Teaching and training in congenital heart disease in Wales for undergraduate, postgraduate and technical staff is undertaken only by the Congenital Heart Disease Centre staff and loss of the Centre would therefore adversely affect training opportunities within the Principality.

4. Restructuring Programme

4.1 The Trust has worked closely with the Welsh Office, Health Authorities and Clinicians in Wales to ensure that the interim arrangements for the service are appropriate and to re-establish a comprehensive service.

4.2 An alliance with another Centre was necessary to allow surgical interventions to be undertaken in another Centre until a surgeon was re-appointed, safely re-establish the surgical service and comply with

clinical governance. An alliance (which has the support of the British Paediatric Cardiac Association) has therefore been formed with The Heart Unit at Birmingham Children's Hospital because it is amongst the largest in the UK, highly regarded clinically, accepts some of the most difficult cases in the UK and has excellent facilities. Such an association does not preclude a liaison with the Bristol Children's Heart Unit.

4.3 The appointment of a Paediatric Cardiac Surgeon has proved difficult. There is only one UK trainee who is still in training. A worldwide search has identified well qualified surgeons working in this field in established international centres however they do not all meet the requirements of the UK specialist register of cardiothoracic surgeons.

4.4 Although suitable surgeons have been identified the Trust has still been unable to make an appointment. The Royal College of Surgeons, who play a key role in approving posts, will no longer endorse the appointment of a single handed paediatric cardiac surgeon in any centre. Following discussions with the College, the President asked Professor de Leval, Professor of Cardiothoracic Surgery at Great Ormond Street Hospital to provide a report on the provision for paediatric cardiac surgery in Cardiff. Professor de Leval's report advises that for the College to support the surgical service in Cardiff, it must join forces with the closest unit to Cardiff, Bristol Children's Heart Unit to create a unit on two sites (see Annex). The College wishes to see a genuine joint venture between the two units to enable surgery to take place on both sites. This would include joint appointments and importantly, the sharing of knowledge, skills and resources for the whole service. Negotiations have begun with the Bristol Unit to explore this option.

4.5 The Congenital Heart Disease Centre has now been without a surgical service for seven months. The Centre is therefore working hard to ensure that links are forged with the Bristol Unit to enable an appointment in the very near future and re-establish the surgical service.

University Hospital of Wales

12 March 1999

Annex

Letter from Mr Barry Jackson, President of the Royal College of Surgeons of England to Dr D J Fisher, Medical Director, University Hospital of Wales

PAEDIATRIC CARDIAC SURGERY IN WALES

As you are aware, I was asked to nominate an independent College representative to the Working Party to set up to look into paediatric cardiac surgery provision in Cardiff.

I have pleasure in enclosing a copy of the report of Professor Marc de Leval, Professor of Cardiothoracic Surgery at Great Ormond Street. This College supports Professor de Leval's recommendations.

I hope you will agree that this takes the matter forward in a constructive way, and I look forward to hearing further from you in due course.

3 February 1999

REPORT ON PAEDIATRIC CARDIAC SURGERY IN CARDIFF

1. Remit

To advise the Royal College of Surgeons at the request of the President on the provision of paediatric cardiac surgical services in Cardiff following the resignation of Mr F Musemeci.

2. Sources of Information

I received a fairly large number of documents and a detailed report of UHW paediatric cardiac programme from Dr. Richard Kirk and some correspondence from Mr Barry Jackson, President of the Royal College of Surgeons.

I visited UHW facilities, spoke to staff and had a meeting there on 21 January 1999 attended by the following people:

Mr E G Butchart, Consultant Cardiothoracic Surgeon, UHW.
Mr E N P Kulatilake, Consultant Carciothoracic Surgeon, UHW.
Mr W Brawn, Consultant Cardiothoracic Surgeon, Birmingham Children's Hospital.
Dr David Salter, Senior Medical Officer, Welsh Office, Cathays Park, Cardiff.
Dr David Fisher, Medical Director, UHW.
Ms Susan Burnett, General Manager, Medical & Regional Specialities, UHW.
Dr Richard Kirk, Consultant Paediatric Cardiologist, UHW.
Dr John Dunne, Consultant Anaesthetist, UHW.

Dr Nula Dunne, Consultant Anaesthetist, UHW.
Dr Paulette Myers, Consultant in Public Health Medicine, Temple of Peace & Health, Cathays Park, Cardiff.
Dr Dirk Wilson, Consultant Paediatric Cardiologist, UHW.

3. Decision Making Process

The following elements must, in my view, be taken into consideration to make recommendations.

3.1 *Background and Activity Profile*

The congenital heart programme at UHW was established in 1991 after a long public and professional campaign. It is now providing the whole spectrum of services in the management of congenital heart disease from prenatal diagnoses to adult services (grown-up congenital heart). The yearly activity consists of 3,000 outpatients, 400 inpatients and approximately 100 operations of which about 70 are open-heart operations. Those operations were performed by a single surgeon, Mr Musemeci, who resigned on 31st August 1998 to return to his native Italy. The results have been excellent, comparing extremely favourably with the best centres not only in the UK but worldwide. Looking at the case mix, he was dealing with all complex neonatal anomalies, such as transposition of the great arteries, hypoplastic left heart syndrome, truncus arteriosus, interrupted aortic arch, etc, which are the most challenging conditions for the paediatric cardiac surgeon.

3.2 *The UHW Position*

Surgery on site is felt to be essential to maintain the cardiology service. Twenty-five percent of inpatients require cardiological procedures that cannot be undertaken safely without a surgical back-up. A loss of those inpatient services would most likely result in the loss of leading paediatric cardiologists in the institution. The loss of the paediatric cardiac surgical patients would also have a negative impact on other services and, in particular, on paediatric intensive care which could no longer be viable.

3.3 *The Welsh Office and Health Authority's Position*

Letters from South Wales Welsh Health Authority and the Welsh Office made it clear that they have reached a strategic decision to maintain paediatric cardiac surgical services in Cardiff. This was confirmed by Dr David Salter, Senior Medical Officer, Welsh Office, at the meeting on 21st January 1999.

3.4 *The Royal College of Surgeons' Position*

Notwithstanding the excellent results of Mr Musemeci's surgery, the College will no longer endorse the appointment of a single-handed paediatric cardiac surgeon. I trust that this view is also supported by the Society of Cardiothoracic Surgeons.

3.5 *My own Views on Surgery for Congenital Heart Defects*

Ideally, the surgical treatment of congenital heart defects should be undertaken by surgeons who are wholly or maximally committed to congenital heart surgery. I believe that a surgeon must operate on at least 200 patients per year to maintain his/her skills. With holidays, leaves of absence for meetings, R & D activities, etc. surgeons working in a two surgeon unit end up by being on a one-in-one on-call rota for the large proportion of the time they are "in town". The ideal unit should therefore have three surgeons dealing with 600 operations or more per year. Accordingly, the number of paediatric surgical units in the UK should be no more than five or six. Major restructuring of the paediatric cardiac services would have to be undertaken by professional bodies, colleges and the government to reach those targets. Nevertheless, it is important, in my opinion, to keep in mind those long-term goals when new appointments and strategic plans are discussed.

4. Options

4.1 Maintain the *status quo.* This is not acceptable to the College (3.4).

4.2 Maintain the same service with two surgeons with a mixed job (adult and paediatric). This appears to be the solution favoured by the paediatric cardiologists. I believe that it would be very unlikely to find two excellent paediatric cardiac surgeons who would be satisfied to share 70 open-heart operations per year. It is also unlikely that this would allow them to maintain their skills and to incorporate new developments without having to go through lengthy learning curves.

4.3 Link with Birmingham Children's Hospital. This link has been established on a temporary basis since the departure of Mr Musumeci. The UHW patients are operated in Birmingham. The cardiac catheters requiring surgical back-up are also undertaken there and the paediatric cardiologists from UHW have weekly joint meetings with the Birmingham medical/surgical team. In practical terms the perpetuation of those arrangements will result in the cessation of paediatric cardiac surgery at UHW. The only disadvantage of fostering this link long-term is the distance between the two units (120 miles). Resources would have to be secured for retrieval and transport services and for parents' accommodation. Although such a link would almost certainly guarantee medical/surgical excellence, it has obvious practical setbacks.

4.4 A link with the Bristol Children's Hospital is the most logical in view of the geographical proximity of the two institutions. The timing of such a joint venture is undoubtedly difficult while the Bristol Public Inquiry

is going on. It is likely that the implementation of a merge with Bristol will have to wait for the end of this Inquiry.

4.4a A merge on one site is the most rational option which would satisfy the Royal College of Surgeons, the Society of Cardiothoracic Surgeons and myself. I think however, that one cannot disregard the fact that the UHW paediatric cardiac programme has been a success story and that the very strong views of the Welsh Office and Health Authority must also be taken into consideration.

4.4b A merge on two sites could, in my view, be explored as a compromising solution to a very difficult problem. To give approval to such an alliance, the College should be satisfied that it would be a genuine joint venture with joint appointments and cross-over between the two institutions. The sharing of knowledge, skills and resources must include the whole cardiac services, medical and surgical, to be genuine.

5. Recommendations

Although a compromise, a merge on two sites (UHW and Bristol) seems to be the most acceptable option. In that context, I would make the following recommendations.

5.1 To initiate negotiations with Bristol outright and to produce a strategic plan that will be submitted to the Royal College of Surgeons for approval before advertising for a new post or consultant paediatric cardiac surgeon.

5.2 To estimate the timing of implementation of those negotiations should they be successful.

5.3 If the merge is agreed but cannot be immediately implemented, the temporary arrangements with Birmingham should be extended. With the agreement of the Birmingham surgeons, I would suggest to advertise and appoint a surgeon in Cardiff as soon as the Bristol link has been approved by the Royal College of Surgeons. This would permit on a temporary basis to restart some surgical activities in Cardiff, making a link on two sites with Birmingham.

5.4 Representatives of the Bristol and Birmingham surgical teams should be part of the appointment committee for this consultant.

5.5 I suggest that a review of the joint services (Bristol/Cardiff) should take place after two years. If unsatisfactory, consideration should be given then to the creation of a single centre on one site.

Marc R de Leval MD FRCS
Professor of Cardiothoracic Surgery
Great Ormond Street Hospital

26 January 1999

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3. Memorandum submitted by the Welsh Office

HEALTH ISSUES IN WALES

1. The Government came into office with a range of commitments and approaches to modernise and renew the NHS. Particular priorities included bringing down waiting lists, abolishing the internal market and reducing health inequalities. In Wales, there was a particular additional focus on improving the seamlessness of care and diverting to patient care the costs of unnecessary bureaucracy by reducing the number of NHS trusts.

2. In the two years since the general election substantial progress has been made across the full range of these issues. This note highlights the progress made so far and the planned actions to continue this progress over the short to medium term. It also provides an assessment of the financial position of the NHS and updates and expands the information provided following the 28 July 1998 hearing.

The White Paper "Putting Patients First"

3. The White Paper "Putting Patients First" was published in January 1998; it introduced a distinctive approach to the strategic management of the NHS in Wales. The internal market and GP fundholding are being abolished. The establishment of Local Health Groups coterminously with unitary authorities has put the key decision-making role for the development of local health services with GPs, other health professionals, local authority representatives and lay and voluntary sector interests. The development of Health Improvement Programmes and Long Term Agreements to replace the internal market contracting cycle has placed a new emphasis on the delivery of high quality health services. White Paper policies aimed at the promotion of clinical quality (detailed below) have brought forward a new era in which maximising activity and the pursuit of quality are of equal importance.

4. Since the publication of the White Paper the department has issued guidance on the Establishment of Local Health Groups and on Recruitment and Remuneration of LHG members, provided a framework for

the development of interim and substantive Health Improvement Programmes and issued guidance on Long Term Agreements and developing clinical excellence. A consultation paper, "Involving the Public" has also been issued to initiate a debate about ways of ensuring greater public accountability and decisions on the future structure of CHCs were announced on 16 March.

5. As a result of the guidance issued, LHGs are now operating in shadow form in preparation to coming on line on 1 April. Health authorities have developed interim framework HIPs and are in the process of establishing Interim Agreements with NHS trusts to replace contracts. The NHS Bill includes a duty of partnership requiring NHS bodies to work with each other and with local authorities. Better integrated services will develop as a result of the closer collaboration.

6. The White Paper also introduced targets relating to cancer services. Work is on course to ensure that any patient with suspected breast cancer will be seen at hospital within five working days of the GP referral. All diagnostic tests required will be carried out in one visit, with patients receiving their results within five working days.

The Green Paper "Better Health, Better Wales"

7. The Green Paper was published in May 1998. In October 1998 it was followed by a Strategic Framework of people for improving the health and well-being in Wales through strategies which promote and protect health, and reduce inequalities in health through the encouragement of sustainable communities, a healthy lifestyle, and a better environment.

8. The main proposals contained in the *Framework* include:

— the establishment of a Wales Centre for Health to provide co-ordinated advice and guidance to the National Assembly on public health issues;

— a National Network for Health to include representatives from all the key organisations across Wales to support the functions of the Wales Centre and to lead and co-ordinate multi-disciplinary action to improve health;

— the establishment within each local authority of Health Alliances to bring together multi-sector agencies to protect and imporve health.

9. A report of a review of health promotion arrangements in Wales was published for public consultation in September 1998. The recommendations have been widely supported by local government, the NHS and the voluntary sector. The recommendations will be implemented by the National Assembly and include a 10 year national strategy for national and legal action to combat unhealthy lifestyles, particularly in communities with the largest health deficits. A three year rolling Action Plan will be developed by Health Promotion Wales (HPW) in its new role as part of the National Assembly. The Special Health Authority will be abolished on 31 March 1999 and the staff and functions of HPW will transfer to the Welsh Office from 1 April 1999.

Waiting Lists and Emergency Admissions

10. The Government came into office with a pledge to reduce the size of the waiting list. Since May 1997, in addition to the very considerable levels of resources invested by the NHS itself in tackling waiting lists, the Government has committed £32 million, to bring the elective list down, while responding to the particular pressures of increased emergency activity during the winter period. It has also given priority to the active management of waiting lists at both health authority and trust level and introduced a number of measures to ensure that local management teams tackle issues in their areas. As a result, from a high of over 76,000 in August 1998, the inpatient/day case list in Wales had fallen to 70,339 by January 1999, and is on course to fall below the level which the Government inherited by end March 1999.

Trust Reconfiguration

11. Following an extensive consultation process, the number of NHS trusts in Wales is being reduced from 26 to 16 from 1 April 1999. Wherever possible the structures of the new trusts follow three principles:

(i) linking neighbouring acute services to remove competition and facilitate co-operation in planning admissions, tackling waiting lists and developing specialist services. There is the potential for rationalising support services to achieve sizeable savings;

(ii) combining acute and community health care (and mental health where possible) to reduce organisational impediments to seamless care from the time of admission to recovery. This should be of particular benefit to vulnerable sectors such as aged people, and should reduce blocking of expensive acute beds by those better cared for in a community setting;

(iii) shared boundaries with unitary authorities ("coterminosity") to assist in co-operation between local government (especially social services) and the NHS. This will also simplify relations with the new local health groups which are also based on unitary authority areas.

12. Although the application of these principles to individual local circumstances has been a matter of concern, they have strong support throughout the NHS in Wales and amongst partner organisations and stakeholders, with a widespread acceptance that current structures are unsustainable clinically and financially. Reconfiguration replaces a set of trusts which—through historical accident—differ widely in size and activity with a more consistent set of trusts better able to meet the changing pressures to which they are subject. This will form an excellent platform from which the National Assembly can drive forward quality improvements. It is estimated that, in due course, savings in management and administrative costs will release around £7m per year for direct patient care. Further savings should be available from rationalising support services.

Quality and Clinical Governance

13. The key clinical quality agenda has been addressed through the publication of the consultation document "Quality Care and Clinical Excellence" in July 1998. This document set out a package of proposals to set clear national service standards, modernise self regulation processes and monitor and assess service quality in more direct and objective ways.

14. The National Institute for Clinical Excellence is being established as a Special Health Authority for England and Wales. National Service Frameworks are being prepared for Coronary Heart Disease, Mental Health and Care of the Elderly. Clinical Governance guidance is under preparation and will be issued shortly. The establishment of the Commission for Health Improvement is progressing through the NHS Bill.

15. In addition, the Government has made progress on particular programmes with the intention of improving the services offered to patients or investing in the fabric and infrastructure of the NHS. Among these are:

(i) *Cancer and Cervical Cancer Screening Services*

Since the general election £3 million of new resources has been made available via all Wales Cancer Services Co-ordinating Group to improve the access to and quality of cancer services in Wales. 29 whole time equivalent (wte) additional doctors have been appointed along with 27 wte nurses, 20 other staff in support specialities and 14 cancer information staff. Partnerships with the voluntary sector have helped establish a Clinical Trial Network and an All Wales Cancer Genetics Service.

A National Service Framework (NSF) for cervical cancer screening in Wales has been developed for implementation in April and responsibility for this key all Wales service is being centralised under the Velindre NHS Trust. The NSF takes account of existing national standards for cervical screening, the recommendations of reviews of the cervical screening programme in England and of reviews by the National Audit Office and the Public Accounts Committee. It establishes a clear line of accountability for the cervical screening programme in Wales and rigid quality assurance measures.

(ii) *NHS Direct*

The Prime Minister announced an extension of the NHS Direct 24 hour telephone nurse triage service during a visit to North Wales on 15 January 1999. My Rt Hon Friend has committed an additional £10 million to the development of this service in Wales. Incremental roll out of the service will commence in West Wales followed by North Powys and a fully bilingual service will be operational across Wales by the end of 2000.

(iii) *Capital Investment*

Since May 1997 work has commenced on six new major projects with a total value of over £60 million. In 1997–98 and 1998–99, over £117 million was made available to NHS Wales for spending on major capital projects. Over £90 million discretionary capital was also made available. In addition, six major projects with a total value of over £22 million have been successfully concluded under the PFI since May 1997 and the NHS is still actively pursuing a wide range of PFI developments. Currently, three major projects with a total value of over £70 million are being progressed with the private sector.

NHS Resourcing

16. As a result of the Comprehensive Spending Review, the health budget has been increased by £175 million in 1999–2000; £345 million and in 2000–01; and £510 million in 2001–02 above previously planned levels. Altogether, the health budget in Wales next year will increase by some 7.1 per cent cash or 4.6 per cent in real terms over 1998–99 levels. Over the next three years the average annual cash increase will be 6.4 per cent or 3.9 per cent in real terms.

17. Final decisions have yet to be taken on the allocation of these resources within the health service but the allocations will need to take account of the impact of pay inflation following the recent pay award announcements. It will also be necessary to make sufficient, but strictly limited, provision to meet brokerage or borrowing requirements.

NHS Financial Position

18. Annex 1 provides the outturn analysis of Welsh NHS Trusts' financial performance in 1997–98 as reported in NHS Wales Summarised Accounts. There are only marginal changes from the figures supplied to the Committee in August 1998.

19. Annex 2 reflects the latest forecasts of trusts' financial performance in 1998–99. Annex 4 shows the position of loans made to trusts and health authorities and Annex 5 analyses the health authority and NHS trust position for Wales broken down by area. These indicate that the in-year financial performance has deteriorated since the last report, with an overall in-year deficit of some £21.5 million now being forecast, some £54.1 million in cumulative terms.

20. Whereas nine trusts operated at a deficit in 1997–98, that number has now increased to 12. Although all are expected to remain within their external financial limit, five are expected to undershoot their 6 per cent return on capital employed target in 1998–99.

21. In Dyfed Powys, the trusts and health authority in-year deficits are expected to amount to some £13.3 million overall, bringing their cumulative deficit to £23.4 million. Together the Trust and Health Authority have required brokerage or loans of some £10 million this year, bringing the total outstanding to £12.51 million. In Gwent the 1998–99 overall forecast position is break even. For Bro Taf a £5.3 million deficit is forecast for the year.

22. Forecasts of overall deficits and brokerage requirements for next financial year are dependent on final decisions on resource allocations. Discussions are taking place to identify the scope and options for reducing the levels of forecast deficit and brokerage requirements.

23. As already announced, a stocktake of the overall NHS Wales position will be undertaken in 1999–2000. Trusts and health authorities forecasting deficits will also be revising their recovery plans over the next few months to ensure that financial balance is achieved in the medium term.

30 March 1999

NHS TRUSTS—ANALYSIS OF PERFORMANCE 1997–98

NHS Trust	Date Trust became Operational	Date Trust was Dissolved	6% Target	Break Even Target			External Financing Limit			Public Sector Payment Policy	
				1997–98 Surplus/ (Deficit)	1996–97 Surplus/ (Deficit)	1995–96 Surplus/ (Deficit)	Target	Actual	Over/ (Under) Shoot	Number of bills	Value of bills
			%	£000	£000	£000	£000	£000	£000	%	%
Acute											
East Glamorgan	01/04/94	—	6.5	168	376	141	10,683	10,683	0	90.7	94.2
Glan Clwyd District General Hospital	01/04/93	—	6.0	167	307	144	1,141	1,141	0	93.3	94.2
Glan Hafren (e)	01/04/93	31/03/96	N/A	N/A	N/A	31	N/A	N/A	N/A	N/A	N/A
Glan Y Mor	01/04/96	—	6.5	13	29	N/A	(1,935)	(1,935)	0	59.4	71.0
Gwynnedd Hospitals (a)	01/04/94	—	5.8	184	295	163	(1,288)	(1,288)	0	93.2	93.9
Morriston Hospital (a)(b)	01/04/94	—	5.0	(1,667)	(2,670)	(288)	6,125	6,105	(20)	86.8	78.5
Nevill Hall and District (a)	01/04/94	—	5.3	18	194	0	(160)	(162)	(2)	93.0	90.2
Swansea	01/04/93	—	6.4	49	49	41	(772)	(772)	0	75.7	85.0
University Hospital of Wales (a)(b)	01/04/95	—	5.4	(1,462)	104	(2,003)	6,940	6,940	0	31.9	43.1
Velindre (a)	01/04/94	—	5.7	23	289	170	88	82	(6)	71.5	66.4
Wrexham Maelor Hospital (b)	01/04/93	—	6.2	(412)	5	5	3,084	3,084	0	82.3	88.0
Acute/Community											
Carmarthen and District (a)(b)	01/04/93	—	0.4	(1,557)	(247)	61	1,216	1,216	0	88.7	94.4
Ceredigion and Mid Wales (a)(b)	01/04/93	—	1.5	(918)	53	(159)	5,542	5.542	0	76.0	88.3
Glan Hafren (e)	01/04/96	—	6.2	330	265	N/A	2,122	2,122	0	45.8	46.8
Llandough Hospital and Community (a)(b)	01/04/93	—	3.8	(1,346)	321	18	4,600	4,600	0	70.3	67.1
Llanelli/Dinefwr (a)(b)	01/04/93	—	2.9	(646)	31	(158)	222	222	0	73.1	74.5
North Glamorgan (a)	01/04/96	—	5.9	54	(2,020)	N/A	(309)	(310)	(1)	65.6	74.1
Powys Healthcare (a)(b)	01/04/93	—	2.0	(900)	308	1	425	425	0	94.7	80.8
	01/04/94	—	6.4	132	241	212	(418)	(418)	0	96.9	97.5
Acute/Community/Ambulance											
Pembrokeshire (d)	01/04/92	31/03/97	N/A	N/A	(225)	3	N/A	N/A	N/A	N/A	N/A
Acute/Community/Mental Health/Illness											
Pembrokeshire and Derwen (a)(b)(d)	01/04/97	—	1.1	(2,039)	N/A	N/A	1,751	1,747	(4)	82.0	83.4

NHS TRUSTS—ANALYSIS OF PERFORMANCE 1997–98—*continued*

NHS Trust	*Date Trust became Operational*	*Date Trust was Dissolved*	*6% Target*	*Break Even Target*			*External Financing Limit*			*Public Sector Payment Policy*	
				1997–98 Surplus/ (Deficit)	*1996–97 Surplus/ (Deficit)*	*1995–96 Surplus/ (Deficit)*	*Target*	*Actual*	*Over/ (Under) Shoot*	*Number of bills*	*Value of bills*
			%	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*%*	*%*
Acute, Community/Mental Health											
Bridgend and District (e)	01/04/93	31/03/96	N/A	N/A	N/A	7	N/A	N/A	N/A	N/A	N/A
Bridgend and District (e)	01/04/96	—	7.1	25	46	N/A	4,844	4,844	0	73.0	74.7
Community/Mental Health											
Cardiff Community Healthcare	01/04/95	—	7.0	315	478	185	(371)	(371)	0	80.8	86.0
Clwydian Community Care	01/04/93	—	6.0	179	345	276	206	206	0	91.8	95.8
Gwent Community Health	01/04/93	—	6.9	30	217	(945)	605	605	0	64.8	77.9
Gwynedd Community Health	01/04/94	—	6.6	63	113	17	2,944	2,941	(3)	90.1	95.3
Mental Health/Illness											
Derwen (d)	01/04/94	31/03/97	N/A	N/A	118	209	N/A	N/A	N/A	N/A	N/A
Dental											
University Dental Hospital	01/04/95	—	7.6	37	119	74	(47)	(47)	0	89.4	85.0
Ambulance											
Mid Glamorgan Ambulance (c)	01/04/94	31/03/98	8.4	0	46	130	(235)	(235)	0	65.4	80.4
North Wales Ambulance (c)	01/04/94	31/03/98	6.6	4	42	55	(289)	(289)	0	78.6	88.9
South and East Wales Ambulance (c)	01/04/93	31/03/98	14.8	58	0	(898)	70	70	0	50.8	60.1
West Wales Ambulance (c)	01/04/95	31/03/98	8.5	0	88	2	(202)	(202)	0	95.0	89.8
All Wales			**5.6**	**(9,098)**	**(683)**	**(2,506)**	**46,582**	**46,546**	**(36)**	**77.6**	**80.9**

(a) These trusts failed to meet their required 6 per cent rate of return.

(b) These trusts reported a failure to break even in 1997–98.

(c) Mid Glamorgan Ambulance, North Wales Ambulance, South East Wales Ambulance and West Wales Ambulance NHS Trusts merged to form the Welsh Ambulance Service NHS Trust with effect from 1 April 1998.

(d) Derwen and Pembrokeshire NHS Trusts merged to form the Pembrokeshire and Derwen NHS Trust with effect from 1 April 1998.

(e) Glan Hafren and Bridgend and District NHS Trusts were dissolved on 31 March 1996. The old Glan Hafren NHS Trust merged with Rhymney Valley DMU to form a re-constituted Acute/Community Glan Hafren NHS Trust with effect from 1 April 1996. Similarly, the old Bridgend and District NHS Trust merged with Hensol DMU to form a re-constituted Bridgend and District NHS Trust with effect from the same date.

Annex 2

NHS TRUST PERFORMANCE 1998–99

NHS Trust	*6% Capital Absorption Duty* %	*Forecast I&E Performance 1998–99 Surplus/ (Deficit)* £000	*External Financial Limit* *Target* £000	*Actual* £000	*Over/ (Under) Shoot* £000	*Public Sector Payment Policy* *Number of bills* %	*Value of bills* %
Acute							
East Glamorgan	6.1	120	8,499	8,499	0	93.0	93.0
Glan Clwyd District General Hospital	5.5	0	6,776	6,776	0	99.0	100.0
Glan Y Mor	6.5	0	(1,658)	(1,658)	0	66.0	78.0
Gwynedd Hospitals	5.3	42	(1,441)	(1,441)	0	96.0	96.0
Morriston Hospital	6.0	(2,438)	1,072	1,072	0	89.0	84.0
Nevill Hall and District	6.1	(212)	(767)	(767)	0	99.0	100.0
Swansea	6.1	0	(963)	(963)	0	76.0	80.0
University Hospital of Wales	6.0	(2,123)	14,251	14,251	0	51.0	58.0
Velindre	6.6	80	2,544	2,544	0	85.0	85.0
Wrexham Maelor Hospital	6.0	(166)	(32)	(32)	0	84.0	87.0
Acute/Community							
Carmarthen and District	6.1	(1,720)	952	952	0	86.0	88.0
Caredigion and Mid-Wales	6.9	(245)	1,197	1,197	0	77.0	86.0
Glan Hafren	6.0	(400)	4,608	4,608	0	19.0	32.0
Llandough Hospital and Community	6.0	(1,892)	2,119	2,119	0	65.0	67.0
Llanelli/Dinefwr	6.2	(700)	184	184	0	79.0	81.0
North Glamorgan	5.2	(367)	(20)	(20)	0	60.0	66.0
Powys Healthcare	5.0	138	(598)	(598)	0	84.0	86.0
Rhondda Healthcare	6.1	101	235	235	0	99.0	99.0
Acute/Community/Ambulance/Mental Health/Illness							
Pembrokeshire & Derwen	7.4	(1,742)	552	552	0	80.0	88.0
Acute Community/Mental Health							
Bridgend and District	7.4	0	(63)	(63)	0	62.0	71.0
Community/Mental Health							
Cardiff Community Healthcare	7.0	270	481	481	0	86.0	93.0
Clwydian Community Care	5.6	159	76	76	0	96.0	98.0
Gwent Community Health	6.5	66	1,235	1,235	0	72.0	81.0
Gwynedd Community Health	7.1	15	2,427	2,427	0	91.0	92.0
Dental							
University Dental Hospital	9.3	(230)	1,696	1,696	0	87.0	88.0
Ambulance							
Welsh Ambulance Service	6.3	48	507	507	0	73.0	73.0
All Wales	**6.1**	**(11,196)**	**43,362**	**43,362**	**0**	**76.2**	**79.9**

Source: NHS Trust monitoring returns.

Annex 3

HEALTH AUTHORITIES—PUBLIC SECTOR PAYMENT POLICY PERFORMANCE IN 1997–98

	Bills paid within 30 day target	
	Number %	*Value* %
Bro Taf	71.6	67.8
Dyfed Powys	85.7	91.9
Gwent	77.1	80.9
Morgannwg	90.4	90.3
North Wales	72.6	61.6
Welsh Health Common Services Authority	89.8	96.5
Health Promotion Authority for Wales	86.9	91.3

(*Source*: 1997–98 audited annual accounts of HAs & SHAs)

Annex 4

CUMULATIVE LOANS POSITION

	Cumulative Net Loans B/Fwd to 31.3.97 £m	*Loans in 1997–98* £m	*Loans in 1998–99* £m	*Repayments 1998–99* £m	*Loans outstanding at 31.3.99* £m
TRUSTS:					
Carmarthen		1.674			1.674
Ceredigion		1.300			1.300
Llanelli		0.650			0.650
Pembrokeshire/Derwen		2.800			2.800
					0.000
Llandough		1.500		−0.500	1.000
Morriston		2.822	1.305		4.127
UHW		1.500			1.500
TOTAL TRUSTS	**0.000**	**12.246**	**1.305**	**−0.500**	**13.051**
HEALTH AUTHORITIES:					
North Wales *Note 1*		1.806	2.475	−0.500	3.781
Bro Taf			2.600		2.600
Morgannwg					0.000
Gwent					0.000
Dyfed Powys	2.510		10.000		12.510
TOTAL HAs	**2.510**	**1.806**	**15.075**	**−0.500**	**18.891**
TOTAL	**2.501**	**14.052**	**16.380**	**−1.000**	**31.942**

Note 1 North Wales HA figures include £0.806m retained land receipts in 1997–98 and a further £0.475m in 1998–99. These amounts will be remitted to the centre to help fund the strategic capital programme.

HEALTH AUTHORITY AND NHS TRUST POSITION FOR WALES BROKEN DOWN BY AREA

	Cumulative (Deficit) as at 31.3.98 £000	*1998–99 Forcast Surplus/ (Deficit) £000*	*Cumulative (Deficit) as at 31.3.99 £000*		*Cumulative (Deficit) as at 31.3.98 £000*	*1998–99 Forcast Surplus/ (Deficit) £000*	*Cumulative (Deficit) as at 31.3.99 £000*	*Cumulative (Deficit) HA & TRUST at 31.3.98 £000*	**TOTAL 1998–99 Forcast Surplus/ (Deficit) position £000**	**Cumulative (Deficit) as at 31.3.99 £000**
Health Authorities:				**NHS Trusts:**						
Bro Taf	(10,973)	(1,300)	(12,273)	East Glamorgan	932	120	1,052		**(1,180)**	**(11,221)**
				Llandough	(864)	(1,892)	(2,756)		**(1,892)**	**(2,756)**
				North Glamorgan	(1,966)	(367)	(2,333)		**(367)**	**(2,333)**
				Rhondda	377	101	478		**101**	**478**
				UDHW	230	(230)	0		**(230)**	**0**
				UHW	(3,361)	(2,123)	(5,484)		**(2,123)**	**(5,484)**
				Velindre	550	80	630		**80**	**630**
				Cardiff Community	978	270	1,248		**270**	**1,248**
Subtotal	**(10,973)**	**(1,300)**	**(12,273)**		**(3,124)**	**(4,041)**	**(7,165)**	**(14,097)**	**(5,341)**	**(19,438)**
Dyfed Powys	(5,143)	(9,000)	(14,143)	Carmarthen	(1,306)	(1,720)	(3,026)		**(10,720)**	**(17,169)**
				Ceredigion	(1,024)	(245)	(1,269)		**(245)**	**(1,269)**
				Llanelli	(606)	(700)	(1,306)		**(700)**	**(1,306)**
				Pembs/Derwen	(2,039)	(1,742)	(3,781)		**(1,742)**	**(3,781)**
				Powys	(33)	138	105		**138**	**105**
Subtotal	**(5,143)**	**(9,000)**	**(14,143)**		**(5,008)**	**(4,269)**	**(9,277)**	**(10,151)**	**(13,269)**	**(23,420)**
Gwent	(3,288)	1,000	(2,288)	Glan Hafren	595	(400)	195		**600**	**(2,093)**
				Nevill Hall	212	(212)	0		**(212)**	**0**
				Gwent comm.	(248)	66	(182)		**66**	**(182)**
Subtotal	**(3,288)**	**1,000**	**(2,288)**		**559**	**(546)**	**13**	**(2,729)**	**454**	**(2,275)**
Morgannwg	881	0	881	Bridgend	71	0	71		**0**	**952**
				Glan y Mor	42	0	42		**0**	**42**
				Morriston	(4,499)	(2,438)	(6,937)		**(2,438)**	**(6,937)**
				Swansea	150	0	150		**0**	**150**
Subtotal	**881**	**0**	**881**		**(4,236)**	**(2,438)**	**(6,674)**	**(3,355)**	**(2,438)**	**(5,793)**
North Wales	(6,307)	(1,000)	(7,307)	Glan Clwyd	1,553	0	1,553		**(1,000)**	**(5,754)**
				Gwynedd hosp.	1,188	42	1,230		**42**	**1,230**
				Gwynedd comm	470	15	485		**15**	**485**
				Wrexham	164	(166)	(2)		**(166)**	**(2)**
				Clwydian comm	1,002	159	1,161		**159**	**1,161**
				WASNT	(367)	48	(319)		**48**	**(319)**
Subtotal	**(6,307)**	**(1,000)**	**(7,307)**		**4,010**	**98**	**4,108**	**(2,297)**	**(902)**	**(3,199)**
TOTAL	**(24,830)**	**(10,300)**	**(35,130)**		**(7,799)**	**(11,196)**	**(18,995)**	**(32,629)**	**(21,496)**	**(54,125)**

Supplementary note submitted by the Welsh Office

We undertook to respond to questions from Mr Llwyd about NHS pay awards. (see Q 202)

— The overall pay bill for the NHS as declared in the Summarised Accounts for 1997–98 is £1.101 billion.

— Health authorities estimate that the cost of the 1999–2000 pay awards and the hangover effect of the 1998–99 awards in full will be £38 million this year, leaving £137 million from the £175 million.

— The recent pay offer by the Management Side of the NHS Whitley Council for laboratory technicians and pathology laboratory workers reflects the generally satisfactory position on recruitment of these staff. It should not be compared with the pay award for nurses which the Government has clearly signalled was a special case.

— The current NHS pay system, however, is recognised as being out of date and holding back the development of staff in the NHS. There is insufficient incentive to take on extra responsibility or develop extra skills. The Government intends a system which provides rewards where they are deserved, is fair to staff and offers equal pay for work of equal value. Radical plans to modernise the way the NHS rewards its staff were announced by the Government on 15 February and details have been circulated to all interested parties.

5 May 1999

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4. Memorandum submitted by Bro Taf Health Authority

PROPOSALS TO TRANSFER SERVICES FROM TALYGARN REHABILITATION CENTRE TO THE ROYAL GLAMORGAN HOSPITAL

As you will be aware in May 1998 the Health Authority undertook a public consultation exercise on the proposals to transfer services from Talygarn Rehabilitation Centre to the Royal Glamorgan Hospital. Despite extensive efforts on the part of the Health Authority, it has not been possible to achieve agreement with the Taff Ely and Rhondda Community Health Council on the way forward.

The CHC has formally opposed the proposals put forward by the Authority and put forward an alternative proposal, which, in turn, the Authority is unable to accept. Therefore in accordance with the guidance on "Substantial Changes in the Use of Health Buildings: Consultation Procedures" issued with WHC (91) 147, the Health Authority referred the matter to the Secretary of State for decision on 11 December 1998.

The Health Authority has requested that the Secretary of State give this matter his urgent consideration and the outcome of the Secretary of State's deliberations on this matter are awaited.

I trust that the enclosed documents (*not printed*) will facilitate the Welsh Affairs Committee discussion on the proposals to transfer services from Talygarn to the Royal Glamorgan Hospital?

Mr P E Davies
Director of Service Development and Policy

1 March 1999

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5. Letter submitted by East Glamorgan NHS Trust

TALYGARN REHABILITATION CENTRE

As requested I have tried to summarise the issues surrounding the proposed closure of Talygarn as we are aware of them from the Trust's point of view (see Annex). As I have explained considerable detail is also contained in the Authority's submission to the Secretary of State and I believe you have already received a copy of this.

Mrs M S Foster
Chief Executive

11 March 1999

Annex

TALYGARN REHABILITATION CENTRE

History

Talygarn House was purchased from the Clarke family by the South Wales Miners' Committee in 1922 and was used as a "convalescent home" for the South Wales mining industry. During 1943 the house was purchased by the Miners' Welfare Commission and re-opened as a Rehabilitation Centre for Miners. It became part of the NHS in 1951. A covenant was included in the conveyance of the property in 1955 that it should "be used and maintained as a Rehabilitation Centre primarily for injured workers in or about Coal Mines and to use the same for no other purpose . . . until not less adequate alternative facilities are available to such workers".

The Centre had 77 beds and until 1982 only men were admitted.

Initial Consultation Process—1990

In May 1990, Mid Glamorgan Health Authority issued a consultation document on the future of Talygarn. At this time the Centre was operating on a five day basis and overnight stays were declining with only 30 beds being occupied on a regular basis. The area of residence of the patients attending during the period leading up to consultation is shown in Table 1 below:

Table 1

AREA OF RESIDENCE OF PATIENTS DISCHARGED FROM TALYGARN IN 1988 AND 1989

Area of Residence	*1988*	*1989*
Mid Glamorgan:—		
Ogwr	182	142
Taff Ely	81	83
Rhondda	63	55
Merthyr	34	41
Cynon Valley	66	60
Rhymney Valley	74	78
South Glamorgan	48	Nil
West Glamorgan	17	Nil
Gwent	20	20
East Dyfed	Nil	4
Not Known	Nil	2
TOTAL	**585**	**485**

Of the patients treated in 1989, 49 were Miners or ex-Miners.

The consultation document issued in February 1991 outlined the intention of Mid Glamorgan Health Authority to establish a College of Nursing at the Centre and gradually reduce the service provided at Talygarn and replace it with locally based Rehabilitation Services. The Health Authority's strategy was to develop services based upon District General Hospital (DGH) sites in Mid Glamorgan over a period of 10-15 years.

This strategic direction required a significant investment in facilities and staff in the Princess of Wales Hospital, Bridgend, and in 1991 the opening of Phase 2, Prince Charles Hospital, Merthyr Tydfil. It was recognised, however, that a purpose built DGH Rehabilitation Department would not be available in Rhondda/Taff Ely until the completion of the new Hospital at Ynys-Y-Plwm. Therefore it was proposed that rehabilitation should continue to be provided at Talygarn on a day care basis until the commissioning of the new DGH, at which time Talygarn would close.

The Secretary of State for Wales subsequently gave his agreement to these proposals in June 1992, although the College of Nursing was never located at Talygarn but was subsequently established at Hensol Hospital and finally incorporated into the University of Glamorgan.

1990–96

As demonstrated in Table 1, by 1989 very few patients were being referred to Talygarn from outside Mid Glamorgan Health Authority. During the years following, patients ceased to be referred from Ogwr and Merthyr/Cynon.

In 1994 when the East Glamorgan NHS Trust was established, Talygarn was not taken into the ownership of the Trust because it was scheduled for closure as a Rehabilitation Service. Therefore, the building remained the property of the Mid Glamorgan Health Authority and the Trust leased the building and continued to provide services to residents of Rhondda, Taff Ely, Rhymney and Gwent. During this period, discussion also took place with the previous South Glamorgan and West Glamorgan Health Authorities regarding the services provided at Talygarn. Representatives of South Glamorgan visited the Centre, but both Health Authorities held the view that they preferred to invest in rehabilitation services within their locality rather than refer patients to Talygarn.

In April 1996 the new Gwent Health Authority assumed responsibility for the Rhymney Valley and the contracts through which the Trust received funding to provide services at Talygarn were as follows:

Table 2

1996–97—TALYGARN CONTRACTS

	Total Attendances	*Patients Treated*
Bro Taf Health Authority	7,928	212
Gwent Health Authority	3,712	128

In May 1996, Gwent Health Authority withdrew its contract and patients from Gwent and the Rhymney Valley were removed by Authority from the waiting list. Subsequent referrals to Talygarn were received from Rhondda and Taff Ely only. Rehabilitation Services of this kind were not included in the GP Fundholding scheme and therefore there were no contracts with Fundholders for this service.

Table 3

PATIENT ACTIVITY 1997

Total New Patients	*Male*	*Female*	*Miners/Ex-Miners*
202	120	82	8

Table 3 presents the number of new patients seen in 1997 and the ratio of male/female and those who were miners or ex-miners. The majority of patients seen during this year were from the Rhondda/Cynon/Taf Local Authority area.

Health Authorities have continued to disinvest in Talygarn in order to develop more locally based rehabilitation services within their own areas. As a consequence of this disinvestment/investment strategy the resources previously available to support Talygarn as specialist centre for South Wales have been withdrawn.

Throughout this period the staff at Talygarn continued to provide an excellent service to the best of their ability. From time-to-time staff shortages had been experienced because of recruitment difficulties which have limited the number of patients who can be seen. Waiting lists have varied but have been settled around 190 patients on a number of occasions with back patients having to wait up to eight months because of the intensive nature of the treatment they receive.

Present Position

Following advice received from the Treasury Counsel in December 1997 that the previous closure approval was time expired, the Bro Taf Health Authority commissioned an independent clinical review of the services provided at Talygarn and East Glamorgan Hospital and those planned for the new Royal Glamorgan Hospital. The outcome of the review considered that the service should be transferred to the Royal Glamorgan Hospital and that this would not constitute a diminution of services and indeed "could lead to an overall improvement in services".

Bro Taf undertook a further three month period of public consultation upon the original proposals in May 1998. Following the consultation period and having considered all responses, the Health Authority reaffirmed its commitment to the transfer of services.

It is recognised that the service at Talygarn will not be replicated in full but this is considered inappropriate considering the catchment population requiring this service and improved approaches to rehabilitative care. However, as a result of further consultation and debate the East Glamorgan Trust has developed proposals to increase the gymnasium facilities available at the Royal Glamorgan Hospital by utilising space currently designated for non-clinical services. This proposal is fully supported by Bro Taf.

It is crucial that a decision regarding the provision of additional gymnasium space is made as soon as possible in view of the stage of design and construction of the Royal Glamorgan Hospital and the impending commissioning of this important health facility.

The rehabilitation service will also be greatly supported by ease of access to other diagnostic and treatment services that are integral to the provision of a comprehensive service.

The Trust and Health Authority contend that this enhancement to therapeutic accommodation should result in rehabilitation services that are equal to though different from that currently provided at Talygarn.

SUMMARY

Since 1996 Talygarn has continued to function as an advanced Rehabilitation Service for Taff Ely and Rhondda only. The main rehabilitation facilities are housed outside the house itself as annexes or outbuildings. Since 1989, the number of patients being treated at Talygarn has fallen from 485 each year to 202. In the financial year ending 31 March 1997, Talygarn treated one Miner and seven ex-Miners. Therefore there has been a reduction in demand for the service which is clearly demonstrated by the lack of referrals from areas outside Rhondda/Taff Ely.

The continued strategy by local Health Authorities of disinvesting in Talygarn to release resources to develop more locally DGH based services has meant that the resources previously committed to support Talygarn are no longer available. The Centre cannot therefore be sustained in its current form reliant upon only minimal local support.

It is estimated that the service costs approximately £500,000 a year to run. As a listed building the main house requires regular investment to maintain its condition and the grounds are extensive requiring substantial attention. Patients use the main house for dining and recreational breaks but it is largely unoccupied. On average the buildings and grounds in total are occupied for approximately 35 hours each week. This is a considerable resource that can be better used in the provision of direct clinical services.

There is also a cost being incurred in providing security for the building on a 24 hour basis. This is required because even during the hours when Rehabilitation Services are operating, the house itself is unoccupied for long periods. Bro Taf Health Authority has remained firm in its decision not to purchase advanced rehabilitation from this site and to transfer the resources consumed by Talygarn to enhance services at the Royal Glamorgan Hospital when it opens. As noted above, attempts to attract patients from other Health Autohrities have been unsuccessful. In view of recruitment difficulties, no attempt has been made to market services on a private basis.

In order to fully utilise the accommodation available at Talygarn, the catchment population being served would once again have to encompass the whole of South Wales. This appears unrealistic considering the strategies adopted of local services for local people and the disinvestment/reinvestment decisions made by Health Authorities over recent years.

There is considerable expert clinical opinion that the continued provision of services from the Talygarn site is no longer appropriate and that rehabilitation services as a whole would benefit in transferring to the Royal Glamorgan Hospital. The critical mass of supporting diagnostic and treatment services that will be available alongside the rehabilitation service is considered an integral component in the provision of an improved comprehensive service. The Trust and Health Authority have seriously considered the views of the public, CHC and other interested parties regarding the future of Talygarn and have responded to these concerns by proposing the development of additional therapeutic gymnasium space.

The East Glamorgan Trust considers that the transfer of rehabilitation services from Talygarn to the Royal Glamorgan Hospital presents the best opportunity of providing a clinically effective service in the most appropriate environment and will better meet the needs of patients who require rehabilitative care.

11 March 1999

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6. Memorandum from the Talygarn Forum

TALYGARN REHABILITATION CENTRE: THE FUTURE

INTRODUCTION

i. This memorandum of evidence makes the case for the retention of Talygarn Rehabilitation Centre as a Specialist Centre for forms of rehabilitative care which are needed and which are not intended to be provided by any other centre in South Wales.

ii. Talygarn Forum is a group of people who aim to:

— prevent the closure of the Rehabilitation Service at Talygarn and the retention of the house and grounds for patient and public benefit;

— expand the Rehabilitation Service by treating a wider range of conditions which would respond to the forms of intensive, group rehabilitative treatment that can be provided at Talygarn.

iii. Talygarn Forum was formed in 1996 when its members became aware of Bro Taf Health Authority's intention to close Talygarn Hospital and dispose of the property in 1999. It published its original statement

of intent, "Talygarn Belongs to Wales" (Appendix 1—*not printed*) in 1997. This document gained extensive public support for its aims.

iv. In 1998 Bro Taf Health Authority was required to consult on its proposals to transfer services from Talygarn Rehabilitation Centre to the Royal Glamorgan Hospital. Talygarn Forum examined these proposals in detail, gaining its own evidence from health professionals and, most significantly, from a survey of patients. Much of this memorandum of evidence is based on the response which the Forum made to the consultation on the proposals of Bro Taf Health Authority.

v. The Health Authority has continued to contest the arguments provided by Talygarn Forum. However, when the Community Health Council considered the issue it agreed with the arguments of the Forum rather than those of the Health Authority (Appendix 2—*not printed*). Once the CHC rejected the proposals of the Health Authority the question of the future of Talygarn Hospital was referred to the Secretary of State who is considering the matter. The Select Committee has an important role to play in scrutinising the proposals of the Health Authority and advising the Secretary of State.

vi. Since the Forum submitted its response to the Health Authority it has gained a copy of the response of Dr Jeremy Camilleri, Consultant Rheumatologist at the University Hospital of Wales, and colleagues (Appendix 3—*not printed*). It is to the advantage of the Forum that it is a group of lay people; it has no professional interest to protect or promote. Nevertheless it was reassuring to find that the conclusions reached by the Forum were separately reached by a group of eminent professionals who have a high regard for the facilities and treatment at Talygarn, and who believe that the Centre is under-used and has the potential to provide efficiently and effectively forms of treatment which are currently unavailable in South Wales.

1. The Nature of a Rehabilitation Service

1.1 The Bro Taf Health Authority consultation paper defines rehabilitation in the following ways:

- "The application of all measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled and handicapped people to achieve social integration"
- "A process of active change where a person who has become disabled acquires the knowledge and skill needs for optimum physical, psychological and social function"

1.2 The Forum believes that the services at Talygarn Hospital are relevant to this definition. We would however broaden the definition of rehabilitation in the following way:

"The use of a variety of forms of treatment to ensure best effect, according to the assessment of conditions and requirements of individual patients with the purpose of:

- enabling a patient to return to a previous quality of life and/or work in the optimum time period;
- improving a patient's quality of life threatened by an inherited disability, disabling accident or disease."

1.3 Talygarn provides this rehabilitative treatment to a variety of groups of patients who currently would not be adequately served by the health service in Bro Taf if Talygarn did not exist, nor will they be if Talygarn is closed.

1.4 Bro Taf Health Authority categorises the forms of rehabilitation in the following way:

- primary and community based rehabilitation necessary for people requiring on-going support and training, very often in their own homes, or for those who require rehabilitative regimes which they will undertake in their own time whilst continuing with their work and home commitments;
- rehabilitation required for in-patients at the District General hospital following operations and requiring high levels of medical supervision, or for those self motivated people who require only infrequent but regular evaluation of their improving mobility;
- very specialist treatment required for people who have suffered strokes or cardiac problems or suffer from other debilitating diseases.

1.5 The Forum recognises the need for all these forms of treatment. However, our disagreement with the Health Authority is based on our conviction that there is a significant group of people in need of a form of treatment which is not covered by the above categories. These are people who need intensive supervised treatment which cannot be provided in the home or at a General Hospital but which is not of the very specialised kind that would be provided at existing specialist centre. These people, of all ages, include those who have suffered from:

- Road traffic accidents
- Industrial injuries
- Sports injuries
- Complications related to orthopaedic treatment
- Muscular-skeletal problems
- Rheumatological conditions

— long term patients with special needs

1.6 Dr Camilleri and colleagues have identified a particular and specific group of patients who fall into the above categories; those suffering from Ankylosing Spondylitis which is a chronic inflammatory spinal disease. There are about 200 new cases of this disease each year in South Wales. The only treatment available in South Wales is in Talygarn but due to the rundown in Talygarn's facilities, many patients are referred to a facility in Bath which is more expensive and has a limited capacity.

1.7 Talygarn Hospital is providing rehabilitation to people who have suffered from such conditions. It is doing so efficiently and effectively. The Forum has surveyed the patients. It is their belief that they need intensive treatment, working in groups, in the sort of environment provided at Talygarn. Bro Taf Health Authority does not claim that this form of treatment will be replicated elsewhere if Talygarn closes; it asserts instead that this is not a valid or necessary form of treatment.

1.8 It is a flaw in the consultation paper that the definition of rehabilitation and the categorisation of forms of treatment excludes from the start the form of treatment provided by Talygarn Hospital.

2. Evaluation of the Service: Clinical Effectiveness and User Evaluation

2.1 The Forum accepts that it is the role of the Health Authority to purchase services which are clinically effective. If therefore the Health Authority is to propose the closure of Talygarn Hospital, it has to prove that alternative forms of provision are more clinically effective. The Health Authority's consultation paper attempts to achieve this by providing:

— a review of published research;

— an independent clinical review of Talygarn Hospital;

— the Health Authority's proposal for an alternative form of rehabilitation to that provided at Talygarn.

2.2 In our response we examined each of these evaluations, but we note that one form of evaluation which is very significantly missing, is the evaluation by patients of Talygarn Hospital. We provided this important form of evaluation in our response.

The Review of Published Research

2.3 In order to make the case against intensive rehabilitation Bro Taf Health Authority undertook a literature search of academic journals for research that has been undertaken on the clinical effectiveness of various forms of rehabilitation. The Forum has checked the references which are generally available. It is our conclusion that the amount of research is limited, the relevance of the research to the service at Talygarn Hospital is not at all direct, and the evidence to be drawn from the research is inconclusive. We note and largely agree with the summary statement in the consultation paper:

> "whilst there is no doubt that Physiotherapy and Occupational Therapy benefit patients there is great uncertainty as to which are the most effective interventions and little or no data comparing differing regimes".

2.4 It is interesting to note that the Health Authority concludes that if the academic research does not prove the effectiveness of Talygarn's intensive treatment, Talygarn should close. The Forum is on far stronger methodological ground, in arguing that if the published research is so clearly inconclusive the relevant evidence must rest on a specific local appraisal of the effectiveness of the Talygarn Hospital. The Forum concludes that Talygarn should remain open until a proper evaluation of the treatment and impact of the treatment at Talygarn has been undertaken.

The Health Authority's Independent Clinical Review of Talygarn

2.5 It was with interest that Talygarn Forum read of the Clinical Review of the service being provided at Talygarn.

2.6 We note that the review is not referenced and it is not therefore possible to know who undertook the review and the nature of the reviewers' independence from the Health Authority. There is no reference to or summary of the methodology employed in the review, although there is mention of "a visit to the centre". The Forum has requested a copy of the full report from the review but this request has been denied. In any proper evaluation if a report is not referenced, has no statement of methodology, is unavailable for scrutiny, its conclusions would not be referred to as evidence.

2.7 Notwithstanding the Forum's view that the Clinical Review should be inadmissible as evidence, we comment on and must contradict some of the assertions included in the report of that review.

— The facilities are not accessible by wheelchair.

> The occupational therapy unit, the hydrotherapy pool and two of the gyms are accessible for wheelchair users. All parts of the Centre are accessible for wheelchairs either from outside or inside, except for Gym 2 and access could be provided.

— The grounds are not used by patients.

Patients do regularly walk around the grounds as part of their treatment to improve mobility. Talygarn is able to provide walks of varying levels of difficulty. This won't be possible at the new hospital which is being built on the flat. Gardening and the use of the greenhouse and garden for the disabled is still part of occupational therapy. Patients use the grounds for playing handball, badminton and football and physiotherapy circuits are held on the lawns in the summer. The facility exists for playing bowls but this has not been properly maintained for years.

— Talygarn is not a clinical environment.

A clinical environment is not defined in the review. However should we define this phrase as meaning a medical centre having a therapeutic input then Talygarn is a clinical environment.

— There is no medical input.

Consultants visit the Centre every two weeks to see their patients and to comment upon the treatment and the impact upon the patients. As the scope and status of the physiotherapist has increased and the physiotherapist is treated as a person able to inform the doctor of the requirements of patients there has been no need for high levels of medical input for those patients treated at the Centre. In the past there has been a matron, nurse, X ray department and consultants held weekly clinics at the Centre. Either these are no longer considered essential to the provision of rehabilitation or they have been dispensed with as part of the process of dis-investment in the Centre.

— The Talygarn Hospital is in need of repair.

Maintenance of the property is required. This is a result of neglect by Bro Taf Health Authority and a lack of investment in the Centre since a decision was made in 1992 to close it. The required maintenance could be undertaken within the existing budget and within a normal maintenance programme.

— There are no local shops or buses for the patients.

There is a post office within a ten minute walk of the Centre. However for the majority of people attending Talygarn there is no requirement to visit shops during the days on which they attend Talygarn. Buses pass the entrance to Talygarn and local taxi services have been utilised when required.

— Bro Taf Health Authority has made adequate provision to replicate the current service provided at Talygarn.

Under the proposed service, for every 10 sessions provided at Talygarn the patient will only receive four sessions at the new hospital.

— The surroundings do not impact on patients receiving rehabilitative treatment.

This is contrary to information received from patients at Talygarn. 56 patients a day, with a variety of problems, are able to socialise at break and lunch times. This provides a communal atmosphere and provides a much needed morale boost.

— The Centre is not a homely environment.

Plenty of homely activities take place in Talygarn. Meal times are communal and use is made of the snooker room, library, television room and the Winter Gardens.

2.8 The Independent Clinical Review has not made the case that the service at Talygarn is ineffective or that the proposed alternative service would be as effective.

The Health Authority's proposal for an alternative form of rehabilitation to that provided at Talygarn

2.9 The consultation paper is confused in its arguments concerning intensive rehabilitation. On the one hand it argues that the degree of intensity provided at Talygarn is unnecessary, and therefore seeks to justify the reduced service to be offered at the Royal Glamorgan Hospital.

2.10 On the other hand the consultation paper accepts that there is a group of patients for whom a daily rehabilitative regime is necessary. The paper, in an off-hand manner, suggests that once the outline of such a regime has been communicated to the patient they may find the relevant facilities at "fitness centres". One might anticipate that the Health Authority has plans for a full working partnership with local authority leisure centres or local private health clubs in which those providers will be commissioned by the Health Authority to provide rehabilitative regimes for individuals as specified by medical practitioners. Such a model will require that these providers are trained, equipped and monitored for the new tasks.

2.11 The Forum has checked with local leisure service providers. They are unaware of any plans by the Health Authority to include them in such forms of provision. The Forum concludes that this assertion by the Health Authority is indicative of the shallowness of its plans for future provision. It is, however, an admission by the Health Authority of the need for intensive forms of supervised treatment for a wide group of patients.

The Forum's User Evaluation

2.13 Talygarn Forum is concerned that the Clinical Review referred to in the consulation paper makes no mention of any attempt to review the expectations and experiences of the service users or of Patient Groups such as Arthritis Care or The Heart and Stroke Association. The Government is currently developing new approaches to developing public services under a framework of "best value". A key feature of this approach is that evaluation of public services should begin with the evaluation of the user rather than the provider; user surveys are an essential part of service evaluation when seeking improved performance from public services.

2.14 Talygarn Forum has undertaken such a user survey. Unfortunately the survey has its limitations. In December 1997 when East Glamorgan Hospital was asked if the Forum could undertake such a survey the response was positive but it was suggested that it should be undertaken by the Community Health Council in order to provide some objectivity. Due to the immense workload of the CHC the survey did not commence until March 1998. And it was not until April that the Forum offered to continue with the survey in order to increase the number of responses and therefore to provide the research with some statistical validity. The survey consisted of an in-depth questionnaire which was completed by 40 of the patients who were receiving treatment at Talygarn during March and April 1998.

2.15 The responses of patients attending Talygarn are very favourable towards the intensive regime. 86 per cent stated that treatment for their condition was not available elsewhere. Many patients had previously received physiotherapy at Community and District General Hospitals or at the GP's surgery. The physiotherapy received elsewhere had been for a maximum of six weeks and for between one and five hours per week, with an average of 2.2 hours of physiotherapy per week. For all those patients little benefit had been gained and further intensive treatment at Talygarn had been prescribed. In the light of this information, it is considered important to investigate the impact of limited physiotherapy on patients, as this is the service that Bro Taf Health Authority propose to offer.

2.16 As explained further in Chapter 3 patients find considerable benefit from the intensive treatment and group therapy received at Talygarn.

3. The Rehabilitation Service at Talygarn

3.1 Since the decision in 1992 to close Talygarn and to provide some facilities at the new District General Hospital, Talygarn has been run down. There has been a lack of investment in the structure of the building as well as in the Rehabilitation facilities and resources. Until March 1998 there has not been a full complement of staff at the Centre for approximately two years. A hoist that had been in the Hydrotherapy pool was removed and has not been reinstated.

3.2 The consultation paper provides evidence that the number of patients being referred to Talygarn Hospital is decreasing and that the geographical origin of these referrals is contracting. It is assumed by Bro Taf Health Authority that this evidence confirms a reduced need for this kind of service.

3.3 Closer analysis of the pattern of referral indicates, however, that the trends in referrals do not indicate changes in service needs but do indicate the protectionist nature of Health Authority commissioning. Between 1986 and 1996 there had been around 100 patients referred each year from the Rhymney Valley. After 1996 there were none. Did this indicate a changing pattern of need in the Rhymney Valley? Clearly not; it merely reflected a change of administrative boundaries as the Rhymney Valley found itself in the Gwent Health Authority which insisted that people in the Rhymney Valley would only receive services provided within Gwent.

3.4 This episode illustrates clearly that health authorities are commissioning in order to protect the interests of their favoured providers and not in the interests of service users. The result of this commissioning behaviour is that specialist providers such as Talygarn, that should be able to rely on a wider source of patients than its own Health Authority, are bound to fail.

3.5 There is a responsibility on the Secretary of State, and after May 1999 the National Assembly, to correct this form of commissioning prejudice by health authorities. It is a reflection of health authority protectionism that results in no patients from outside of Bro Taf now being referred to Talygarn.

The Waiting List

3.6 The report states that in May 1997 there were 172 patients on the waiting list for Talygarn for an average time of 12 months. In January 1998 there were 136 patients on the waiting list waiting on average nine months. It is inferred that this short term trend is due to less referrals and a diminishing need for the service. In fact, it is due to the employment of more staff and more patients receiving treatment. In May 1997 there were fewer physiotherapists employed than in January 1998.

Referrals

3.7 It is stated that one consultant is responsible for half of the activity (patients) referred to Talygarn. From the survey undertaken by Talygarn Forum this is not the case. Twenty nine referrals have come from 13 consultants; and the highest number of referrals from any one consultant is seven.

3.9 It is known that patients are also referred from Rookwood and Llwynypia hospitals for the intensive on-going treatment that Talygarn is able to provide. There is evidence that these hospitals may not be providing treatment as effective as that in Talygarn; the Forum has identified 15 patients who completed their treatment at Rockwood and were then referred on to Talygarn. Why was the initial referral not to Talygarn?

3.10 The Health Authority report stated that in April 1998, 97 patients were on the waiting list for the following reasons:

— 76 with rheumatology complaints;

— one following neurosurgery;

— eight following trauma and orthopaedic operations from within Taff Ely and Rhondda;

— two following trauma and orthopaedic operations from UHW.

3.11 Though Talygarn Forum is unable to dispute the above facts, our findings of the reasons for people currently receiving treatment at Talygarn show more variation in the medical conditions for which patients require rehabilitation and includes nine patients with neurological conditions.

Access to the Waiting List

3.12 The consultation paper concludes from its analysis of activity at Talygarn and based on assumptions about referrals of patients that there is a decreasing demand for treatment at Talygarn. Talygarn Forum would dispute this assertion. There are many people known to members of the Forum who have asked to be referred for treatment at the Centre but who have been refused. Consider the following example taken from a letter to the Forum:

> "My wife . . . who is 30 years old suffers from Multiple Sclerosis . . . We read, in all the journals of societies representing all the crippling diseases, of the benefits of pool therapy. So why is my wife denied referral for such treatment?"

3.13 This form of evidence is being ignored in order to justify the lack of demand and to prevent the possible suggestion that intensive treatment can improve the quality of life of people suffering from diseases that debilitate.

3.14 It may be argued that some of these people requesting treatment are local to Talygarn and that there would not be such a demand from other areas. However it is known that due to the uncertain past and future that many people are under mis-apprehension that Talygarn has closed. It is also understood that some consultants have been requested not to refer patients to Talygarn because the Centre is in the process of being run-down. The Health Authority is justifying its proposals to close Talygarn by its evidence of diminishing demand. However, actions in restricting Talygarn's resouces and manipulating the referral process, Bro Taf and other health authorities are creating the conditions that support their own conclusions.

Group Therapy

3.15 In discussions that Talygarn Forum have had with both Bro Taf Health Authority and East Glamorgan Health Trust, the Forum has stressed the positive psychological effects of group therapy. The positive impact of this aspect of treatment at Talygarn has been re-inforced by the patients answering the Forum's questionnaire.

> "The group therapy is essential as part of physiotherapy."
>
> "Talygarn exists for the mind as well as the body. Patients who have been out of work suffer from problems like depression."
>
> "After my accident I felt heavy with despair and loneliness. There was no light at the end of the tunnel. Having been to Talygarn for the last three months and savoured its unique atmosphere and facilities, I am far more hopeful about my recovery. Talygarn's combination of excellent treatment, team and group support, ample varied exercises, weights, gymnasium and circuit training and hydrotherapy provide a stable and vital platform for re-introduction into normal life."

3.16 It is interesting to note that none of the research referenced in the Health Authority's proposals makes any reference to the psychological impact of group therapy in rehabilitation or the necessity of a positive psychological attitude to rehabilitation. What some of the research identifies as to a placebo effect may in fact be a response to group therapy.

Intensity of Treatment

3.17 Bro Taf Health Authority argues that the level of treatment at Talygarn is not required. It has no proof of this but insists that all the patients currently being treated could be provided with an effective service either in the community or at the District General Hospital. One of the survey respondents would disagree.

> "Talygarn offers a complete service to each patient. The staff are very dedicated and concerned with each patient. This service would not be available in a normal hospital ie half an hour in the pool and half an hour of physio."

3.18 Talygarn Forum has continually argued that it is the group therapy and the intensity of treatment that is so beneficial to so many patients. Again, consideration ought to be given to the views of users of the Talygarn Rehabilitation Centre:

> "I have received physiotherapy at East Glamorgan, GP's surgery and privately but it was felt that more intensive physiotherapy was necessary."
>
> "In five weeks since I have been here it has been very hard going, but beneficial to me. The staff encourage you to take part in activities you wouldn't normally do, they have given me the confidence to partake in exercises I haven't done since my injury. My knee is now a lot stronger and I am a lot fitter than when I started."
>
> "I suffer from Guillain Barre and was sent to Talygarn by Social Services. This took me from being a wheelchair user to being able to cope, do small tasks for myself and also gain back my personality, self confidence and my husband was able to return to work and I am not now trapped in a wheelchair."
>
> "I was struck down with Guillain Barre just over two years ago but I was one of the lucky ones to be sent to Talygarn. I am now cured and have returned to work."
>
> "I had a severe stroke at 29 and it wasn't until I was ill that I heard of Talygarn. When I first arrived I was stuck in a wheelchair with my head held back and the only pleasure I had was admiring the beautiful ceilings. It helped me a great deal to mix with other patients. I now have a better lifestyle. Talygarn is the best thing that happened to me and I will never forget those ceilings."

Methods of Providing Treatment

3.19 The Health Authority proposes that a small working group will consider which interventions show most promise and that it will then be possible to produce care packages tailored to the needs of individual patients. The authority believes these can be equally effective whilst being a more efficient use of resources. However if one studies the provision of treatment at Talygarn it will be noted that individual treatment packages are designed for each new patient. And there are cases where staff propose that rehabilitation at Talygarn is not suitable for a patient and for the patient to be referred back to the consultant. The design of individual packages of treatment at Talygarn only differs in the intensity of the treatment that is available and provided.

3.20 We state again that the arguments made by Bro Taf Health Authority for closing Talygarn are not based on evidence of the effect of the treatment.

4. Can the Service at Talygarn be Replaced?

The Level of Service

4.1 When Talygarn Rehabilitation Centre has its present full complement of staff it is able to provide 56 patients with 10 units of treatment a week incorporating physiotherapy, hydrotherapy and occupational therapy. A unit of treatment is defined as a half day session.

4.2 The initial plan for the Royal Glamorgan Hospital is to provide 24 patients with three units of treatment a week. In response to criticisms the Health Authority is considering a revision of these plans to accommodate 32 patients with four units of treatment a week. This revision requires an unplanned, and uncosted, expansion of the physiotherapy department and the conversion of the administration block into a gymnasium.

4.3 These figures clearly illustrate that the new service will be a reduction of that currently provided. The plans can only be justified by the unverified assertion that the intensity of the treatment at Talygarn is ineffective and unjustified. As we have shown this assertion is not supported by research evidence and neither is it supported by the experience of patients.

The impact of treatment at Talygarn

4.4 This diminution of the service is based on the view held by Bro Taf Health Authority that positive impact of intensity of treatment and the beneficial effects of group therapy have not been proved. However as Talygarn Forum has found from the evaluation of the users of the service both of these aspects of the

treatment are extremely beneficial along with the benefits of physiotherapy and rehabilitation and are important in helping people:

— return to their previous quality of life;
— to improve their quality of life;
— regain self confidence;
— fight depression that comes with illness;
— maintain a normal family life.

4.5 The case studies collected by the Forum illustrate the potential of Talygarn's service to give patients and their families the confidence and the capacity to be more self-reliant and to re-enter employment. This intensive form of treatment therefore has a beneficial effect on the cost to central government of benefit payments and the costs to local government of social services. It may well be that the Health Authority is unable to take into account these external benefits and it requires the intervention of the Welsh Office to bring these factors into consideration.

What can be provided at the Royal Glamorgan Hospital?

4.6 Bro Taf Health Authority argues that at the new hospital it is possible to provide closer multi-disciplinary working arrangements, access to a full range of diagnostic facilities and development of a specialist medical lead; and that none of this is possible at Talygarn. It should be noted that Talygarn Hospital will only be ten minutes drive away from the Royal Glamorgan Hospital. Rookwood is a similar distance from University of Wales Hospital. If there was a new commitment to integration and medical support it could be achieved without the relocation of the service. The Forum concludes that the motivation for the proposed transfer is not the integration of services butthe reduced intensity of the service at an assumed lower cost.

4.7 Bro Taf Health Authority argue that patients will be able to use the grounds of the new hospital for outdoor activity. The Forum has examined the site of the new hospital and is unable to identify the potential for the sort of outdoor activities available at Talygarn; the external environment of the hospital is very largely a car-park.

Impact on the Waiting List

4.8 Should Talygarn be closed it is possible to argue that the waiting list will increase in response to a slower return to or improvement of people's quality of life. Fewer people will be treated for fewer sessions.

5. The Financial Argument Against Closure

Financial Assessment of Services

5.1 We would have expected the Health Authority's proposals would have provided a proper evaluation of the outputs and outcomes of the service options alongside an evaluation of the financial costs. We have already argued that we do not regard the review of clinical effectiveness as a reliable evaluation of outputs and outcomes. We are, in addition, surprised to find no reference to the relative costs of the options under consideration, ie retain the services of Talygarn or transfer those services to the Royal Glamorgan Hospital. There is simply the argument that investment has already been committed to the new hospital and this inevitably squeezes out all other options. It has been admitted that the capital costs of providing the service at the Royal Glamorgan Hospital are higher than those of providing the service at Talygarn.

Income Generation

5.2 The price of providing a rehabilitation Service at Talygarn is low. We have been informed that the current price of Talygarn services is approximately £65 per unit of treatment.

5.3 If Talygarn were operated at its current capacity it would provide 20,000 units per year of treatment resulting in an annual income to the Health Trust of £1,200,000. The Forum believes that such potential income is significantly greater than potential costs. It is unfortunate that the Health Authority has not provided a cost structure for services at Talygarn and at the Royal Glamorgan Hospital. The Forum fears that this black hole in the consultation paper conceals higher costs, higher prices and a lower level of service.

5.5 The consultants' letter in Appendix 2 (not printed) explains that currently a few lucky patients have been referred to the Rheumotology Hospital in Bath at a current cost of £2,608 for 14 days programme of treatment. At current costs of treatment at Talygarn, treatment could be provided for £980. The consultants' note that the Bath treatment is expensive and as a result patients can only attend one programme per year whereas patients would benefit from attending such a programme twice a year.

The Losers

5.6 The losers will be the patients of the National Health Service who are unable to receive the same level of treatment or will have to wait longer for treatment at the new hospital to the detriment of their recovery.

5.7 As previously stated the treatment at Talygarn can result in a reduction on the reliance on other services, benefit payments, community resources, community medical facilities, doctors, social workers and therefore a reduction in the cost to the welfare state.

6. The Provision and Location of a Specialist Service

6.1 The consultation paper reports that Bro Taf Health Authority is considering the need for a specialist rehabilitation centre to meet the needs of those patients with severe and complex neurological problems caused by disease or damage to the nervous system and for patients with primary neurological disease.

6.2 This is, in part, a different group of patients to those currently served at Talygarn, although as noted in paragraph 4.11, nine of the current patients have been referred to Talygarn for intensive rehabilitation treatment because of neurological problems. The case for retaining the rehabilitation service at Talygarn as currently provided, intensive, and responsive to a wide group of patients, is not affected by this intention.

6.3 Nevertheless, the Forum encourages the Health Authority to give serious consideration to the use of Talygarn for this specialist centre alongside its continued use as a centre for intensive rehabilitation for the wider group. There is spare capacity in the buildings and the environment is likely to be as much appreciated by the group of patients who require the specialist service as it is by the current group of patients.

6.4 The use of the existing buildings, albeit adapted and renovated, is likely to incur lower capital costs than investment in new buildings on a new site. The high capital costs of services at the Royal Glamorgan Hospital is evidence to support this argument. It must be noted that the Private Finance Initiative may create new sources of capital finance but it does so at an increased cost. It is important to control capital costs, and investment in Talygarn for a range of specialist and intensive forms of rehabilitation is likely to prove cost effective.

6.5 Enclosed in Appendix 2 (not printed) is a letter from six consultants employed by Bro Taf Health authority who agree with this proposal. Two of the consultants visited Talygarn and concluded that it should be "used to provide the facilities needed for a South East Wales ankylosing spondylitis service".

7. Conclusion

7.1 The case for transferring services from Talygarn Rehabilitation Centre to the Royal Glamorgan Hospital has not been made by Bro Taf Health Authority. The Talygarn Forum opposes the proposals.

7.2 There is a group of people who need an intensive and supervised form of rehabilitative care that cannot be provided by the Royal Glamorgan Hospital, neither can it be provided in the community. The consultation paper recognises the need for more intensive forms of provision than can be provided by the Royal Glamorgan Hospital and it has not suggested a viable alternative to Talygarn. The reference to fitness clubs undermines the main argument in the consultation paper.

7.3 The Talygarn Forum welcomes the intention of Bro Taf Health Authority to develop a specialist rehabilitation centre and recommends that this is developed at Talygarn alongside the current provision of intensive care.

7.4 It is recognised that the maintenance of the large, historic gardens in Talygarn is a responsibility that may be ill-suited to the core business of a health care organisation, even though they are of mush benefit to the users of the rehabilitation centre. These gardens are a much valued community asset, used by local people, voluntary organisations and local sporting clubs. The Forum suggests that the gardens are transferred to the local authority, either Pontyclun Community Council or Rhondda Cynon Taff County Borough Council. The transfer could provide conditions relating to the maintenance of the gardens and continue the access to users of the rehabilitation centre. The local authority, working in partnership with voluntary organisations and the Health Authority, could use this facility for a variety of services for groups in need of care and assistance; and there may be scope for integration of this form of care with the services of a rehabilitation centre. The local authority could promote the future use of the gardens for the leisure and sporting interests of the community.

7.5 Our recommendations are consistent with the history of Talygarn which is a significant part of the historic legacy of South Wales. It is currently in public ownership because of the voluntary investment by the miners of South Wales and their families. The Health Authority and the Secretary of State have a responsibility to act with imagination and a sense of duty to make best use of these facilities in the public interest and in the particular interest of those who need an environment conducive to effective rehabilitation.

7. Letter submitted by SCOVO

HEALTH ISSUES IN WALES

I am pleased to enclose a summary briefing on the campaign for the completion of hospital resettlement in Wales for people with learning disabilities (Annex 1). On 31 January 1999, Ely Hospital in Cardiff officially closed, bringing to an end a 16 year process. Residents remain at three large hospitals: Bryn-y-Neuadd near Llanfairfechan, Hensol near Pontyclun and Llanfrechfa Grange near Cwmbran.

The campaign is being directed by a resettlement task force, convened at the request of the Management Committee of SCOVO. It includes representation from Mencap in Wales, the All Wales Parents and Carers Forum, advocates and advocacy organisations and First Choice Housing Association.

We trust that members of the committee will be concerned about what is the longest waiting list in Wales.

Mr J G Crowe
Director

15 March 1999

Letter submitted by the Resettlement Task Force

CAMPAIGN FOR THE COMPLETION OF HOSPITAL RESETTLEMENT IN WALES FOR PEOPLE WITH LEARNING DISABILITIES

I am writing on behalf of the Resettlement Task Force, a coalition body with which Mencap in Wales is working to campaign for the completion of hospital resettlement in Wales for people with learning disabilities. We wish to highlight our concerns regarding the continued Welsh Office delays in establishing appropriate support services in the community for people with learning disabilities. The absence of such important services is resulting in the continued and unacceptable incarceration of 450 people with learning disabilities in long stay hospitals in Wales.

I enclose a copy of the summary briefing Annex 1.

Mr Simon Wright
Campaigns Officer, Mencap

18 March 1999

Annex 1

CAMPAIGN FOR THE COMPLETION OF HOSPITAL RESETTLEMENT IN WALES FOR PEOPLE WITH LEARNING DISABILITIES

A Summary

The Campaign for the completion of Hospital Resettlement in Wales for people with learning disabilities seeks to end the longest hospital waiting list of all. The principles underlying the campaign are the familiar, but often ignored, principles of the All Wales Mental Handicap Strategy:

— a right to an ordinary pattern of life in the community;
— a right to be treated as an individual;
— a right to additional help and support in developing their maximum potential.

Long term incarceration in hospital through lack of community alternatives strikes at the heart of these principles. This is not an issue of policy or economics, but one of human rights. David's story, as told by his mother, is typical.

"My son David has been a resident of Hensol hospital since he was 16 years old in 1980. He has had a good relationship with the staff over the years and around February 1996 David was told 'that he would be out in the community in 12 months from April'. Then last year he was told that he would be out in March 1999 and it doesn't look like he will be out then. He is looking forward to coming out and they say they would look for areas near to me making it easier for the family to visit him. He keeps asking every time I see him 'When am I getting out?' and it is making him distressed because we can't give him a definite date. I would like to see him out in the community because he has great plans."

Currently there are 450 people left in the three large long stay hospitals in Wales—Llanfrechfa Grange, Hensol and Bryn y Neuadd. There are no clear and agreed plans for resettlement for these people.

Why are They still Waiting?—A History of Broken Promises

1983—The All Wales Mental Handicap Strategy was launched.

1989—The term "comprehensive resettlement" first used by the Welsh Office meaning that all hospital residents were to be resettled back to community settings.

1991—Welsh Office Circular envisaged that support and accommodation would largely be provided in ordinary flats and houses, in local communities and that individuals would normally not share with more than three or four people.

1993—Llwyn View, Broughton and Coed Du hospitals close showing that it can be done.

1994—Welsh Office Circular made the objective of full resettlement explicit and made Health Authorities and Local Authorities make firm plans to:

— resettle the residents of long stay mental handicap hospitals into more homely settings in the community;

— relocate other care and support services into community based settings . . . thus allowing the closure of hospitals;

— resettlement to be complete by 1 April 1999 and all remaining hospitals to close over the next five years.

but then . . .

1994—Welsh Office conclude that resettlement should concentrate on Ely with resources being made available for resettlement from other hospitals at some time in the future.

1998—Welsh Office make funding available for 10 individuals. Consideration of remaining resettlement is deferred until after the start of the Welsh Assembly—after 1 April 1999.

Some Facts About Resettlement

Resettlement is complex. It takes at least two years in most instances from plans being agreed to people moving. The size and scope of the task cannot be underestimated.

The stress of waiting is very real for all 450 people involved—and for their families and carers.

Resettlement will cost more money than is currently being spent on these 450 people in some instances considerably more if it is to be done properly. But resettlement is not about saving money—it is about ending poor care to the must vulnerable citizens in our society.

Unless we resettle people, transfer resources and close the hospitals there is a real danger that they will begin to fill up again with our children and young adults. Future generations should have local not institutional services.

It will not be possible to gain the commitment of local authorities unless some protection is made by the Welsh Office for resettlement funding.

More people have died waiting for their move in the remaining three hospitals in Wales than have been resettled. Some have also been transferred from one institutional setting to another.

Anyone can live in the community regardless of their additional health and social needs. Ninety-five per cent of people with learning disabilities in Wales already do so.

People in hospital are "socially excluded" in a way that nobody else is in Wales.

Our Campaign Aims . . .

— completing the resettlement of all people in long stay mental handicap hospitals by the end of the first term of the Welsh Assembly;

— ensuring that sufficient funding is available to meet both the one off and recurrent cost of resettlement within this time frame;

— ensuring that the ringfencing of funding remains in place for all resettlement monies;

— ensuring the appropriate co-ordination of individual planning takes place between the Welsh Office, Hospitals and Local Authorities;

— ensuring that all the hospitals close completely and do not reconstitute themselves as "continuing care facilities";

— ensuring that no-one is placed in inappropriate alternative institutional settings;

— ensuring that each person and their family and advocates are fully involved and informed;

— ensuring that creative and individualised means are used to meet people's needs in the community.

8. Memorandum submitted by North Glamorgan NHS Trust

INEQUALITIES IN HEALTH IN WALES

1. Introduction

1.1. Since the Black Report [1], whose conclusions have recently been reinforced by the Acheson Report [2], the factors adversely affecting the health of populations have been well documented. It is government policy to redress the inequalities of health which result. Whilst many of these require action over social factors such as education, housing and employment, those trying to deliver health care currently have to deal with the adverse consequences of decades of neglect. This logically involves spending more per capita on the health of deprived populations. It is the contention of this Memorandum that this is not happening and that current practices are generating just the opposite effect.

1.2. We believe that North Glamorgan NHS Trust is uniquely placed to document this assertion. It serves the most disadvantaged community overall in Wales for acute, community and mental health services. It is the only "pure" Valleys Trust, undiluted with pockets of more affluent catchment areas. Yet its resources are insufficient to provide services comparable even to those elsewhere in its own Health Authority Area (Bro Taf) let alone elsewhere in the Principality. All the assertions made in the following paragraphs are derived from official statistics.

2. Measures of Need

2.1. The accepted indicator of deprivation is the Townsend Score which reflects many factors including unemployment, lack of car ownership, non-owner occupied households and overcrowding. The all-Wales score is 1.6, the score for Merthyr and Cynon is 3.4 (itself the highest score in Wales) and the Gurnos ward, in which Prince Charles Hospital is situated, is a staggering 9.0 [3].

2.2. Other more specific indicators support this rather generalized measure, viz:—

- — Unemployment is in excess of 11 per cent (All Wales 6.7 per cent) [3,4].
- — Physical health status is the lowest in Wales [4,5].
- — Mental health status is the lowest in Wales [4,5].

3. Effect on Health Status

3.1. The Merthyr and Cynon Valleys, by comparison with other catchment populations in Wales have:—

- — The highest overall mortality rate [4,6].
- — The highest number of years of life lost for those aged less than 75 years [6].
- — The highest death rate from strokes [6].
- — The highest death rate from respiratory disease [6].
- — The second highest death rate from cancers [6].
- — The third highest death rate from heart attacks [6] (highest within Bro Taf [3]).
- — The second highest level of Limiting Long-term illness in Wales [3,4].

3.2 This pattern of illness places greater than average demands on the health services. For example, after correcting for catchment population size, by comparison again with all-Wales:

- — We have more new accident and emergency attendances than any other trust [4]
- — We are third in Wales in the number of new out-patient attendances [4]
- — We have the highest rate of in-patient hospitalisation [3,4]
- — We are fifth highest in the number of day cases treated [4]

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[1] Black D, Morris JN, Smith C, Townsend P. *Inequalities in health: report of a research working group.* London: Department of Health and Social Security, 1980. (Black Report.)

[2] Acheson D *Independent inquiry into inequalities in health.* London: Stationery Office, 1998. (Acheson Report.)

[3] Bro Taf Health Authority Profile, 1997.

[4*] Digest of Welsh Local Area Statistics 1999.

[5] Welsh Health Survey, 1995.

[6*] An Atlas of Health Inequalities between Welsh Local Authorities, 1998.

* (These report figures by Local Authority Area. Merthyr is a Local Authority in its own right but Cynon, although served by North Glamorgan Trust, is part of Rhondda Cynon Taff (RCT) in which the more affluent Taff improves RCT ratings overall. As in all the aspects in which Cynon can be separately identified, its situation is either equal to that in Merthyr OR WORSE, we have taken the view that the figures for Merthyr can be taken to represent Cynon as well.)

4. Deficiencies in Provision

4.1 One might suppose that the combined evidence of a severely deprived population and the evidence of the consequential low health status would result in the successive Health Authorities responsible for this area's funding trying to remedy the situation. Just the opposite seems to have occurred.

- Despite having the lowest mental health status in Wales, there is no local High Dependency provision for dangerous patients, no adult day hospital (the only Trust in Wales so deprived) no EMI day hospital in the Cynon Valley and no separate hospital-managed rehabilitation service
- Despite having the highest proportion of its children on the "at risk" register, the Trust has the lowest number of Health Visitors per unit of population [7]
- Despite having the highest incidence of death from heart attack in Bro Taf, there is only one cardiologist. Every other trust in this Health Authority Area has two or more
- Despite having the highest number of deaths from stroke per unit of population, there is no stroke unit
- Despite having the highest number of deaths from respiratory disease per unit of population, there is only one physician responsible for adult respiratory medicine
- Despite having twice the number of diabetics than the Health Authority average and a Royal College of Physicians recommendation, there is only one diabetologist where two are needed.

5. Is it the Fault of Poor Management?

5.1 Although we would naturally deny such an assertion, official figures also refute it. Despite being a "last chance" 4th wave Trust (because of its manifest unpreparedness under Mid Glamorgan Health Authority's stewardship) the Trust:

- has met its financial targets
- has earned high commendation from its auditors for its systems improvements
- has never closed its doors to emergencies
- has over performed on all its major contracts every year
- has managed the highest *per capita* number of accidents and emergencies
- has the lowest in-patient and day case waiting lists in Bro Taf and one of the lowest for an integrated trust in Wales
- will meet its waiting list reduction targets.

5.2 This has been achieved despite being burdened with mostly old buildings, and estimated £25,000,000 backlog of maintenance when the Trust was set up and an independently assessed recurrent deficit of £2–3 million in annual funding. What has NOT happened, is the introduction of so-called "developments" which would in fact amount to no more than remedying the glaring deficiencies listed above.

5.3 This demonstrates that the problems lie outside the control of the Trust's managers.

6. What Are The Root Causes?

6.1 We discount any deliberate malignancy on the part of Purchasers and recognize that our funding difficulties are not unique. The historic underfunding of the NHS is a big factor, but one which impacts particularly hard when there is no "fat" to trim. The recent injection of additional funds is obviously welcome, but the impact has been diluted by being used to reduce the overall deficits rather than being targeted to where the need is greatest.

6.2 This is not to say, however, that there are not attitudes to the problem and its resolution, which may be partly subconscious. Furthermore, they may flow from a deliberate well-meaning but misguided attempt to make longer-term strategic health delivery improvements at the expense of the immediate problems. It would take a long essay to discuss these attitudes and their basis in detail and this section will focus on just two: the alleged minimum effective size for a comprehensive District General Hospital (DGH) and the influence of socio-economic mix.

6.3 The idea that it is not possible to provide a quality DGH emergency service for population units smaller than 400,000–500,000 was promulgated by the Royal College of Surgeons of England, and was in conflict with recommendations from the Royal College of Physicians concerning the continuing need for generalist physicians to staff smaller DGHs. Under pressure, these bodies with the British Medical Association then produced and published an agreed view [8]. At the moment the Academy of Medical Royal Colleges has asked them to redraft it because of a failure to consider adequately the problems posed for other specialties such as

[7] District Audit Report on Health Visiting, July 1998.

[8] Provision of Acute General Hospital Services: report of a joint working party of the Royal College of Surgeons and the Royal College of Physicians *British Medical Journal* 1998; 318: 151.

pathology and anaesthetics (personal communication, Professor L Strunin, Vice President of the Academy of Medical Royal Colleges). Yet its reliance on opinion rather than evidence has not prevented its authoritative tone from influencing thinking at Health Authority level where the wisdom, truth and inevitability of their thesis seems to have taken root and be influencing decisions.

6.4 This model may well be appropriate for urban areas of England but that is far from saying that it is universally applicable. If it were applied to Wales there would be only seven DGHs instead of the current 16. The result of the recently concluded reconfiguration exercise has demonstrated that Ministers have implicitly not accepted this model as universally appropriate in Wales.

6.5 Even if it is an appropriate model for the major conurbations such as Swansea and Cardiff (where most of Bro Taf's population reside) its extension to the surrounding Valleys is not only unjustified but unacceptable. Geographical imperatives decree that the patients in the Merthyr, Rhymney and Cynon Valleys would find it next to impossible to travel to the Royal Glamorgan Hospital at Llantrisant and would gravitate instead to the University Hospital of Wales.

6.6. This would result in the provision of a locally accessible DGH for well-off residents of Cardiff with cars and good transport connections but for the impoverished residents of the Valleys, without cars and inadequate transport links, a need to travel 25-30 miles for quite routine investigations such as an MRI scan or many operations such as those for middle ear disease, vascular disease and head and neck cancer, not to mention all casualties other than minor ones.

6.7. Such a strategic vision is morally and socially indefensible and unacceptable to any political Party. And yet, there is undoubtedly a (possibly unconconscious) attitude that any successful attempt to bring the services provided for the residents of the Merthyr, Cynon and Rhymney Valleys up to the standards acceptable elsewhere, will make it more difficult to achieve the ultimate aim of "hub and spoke" arrangements which will downgrade the local provision in the interest of economy and "better" care. The result is to exacerbate the current unsatisfactory situation and make it "inevitable" that a centralist solution can eventually be sold as better. On geographical grounds alone the Colleges' option is unacceptable for the Valleys. These communities need appropriate numbers of medical and other staff to provide locally accessible comprehensive secondary care: rationing by location is unacceptable.

6.8. If the continued existence of DGHs which serve smaller populations is to go hand in hand with the provision of a high quality service, the inevitable corollary needs to be clearly understood. Small DGHs cost more per head of population than large DGHs to achieve the same level and quality of provision.

6.9. To take a simple example, if the UHW NHS Trust is persuaded that there is a need for half an additional haematologist, the only practicable solution of employing an extra whole one will result in employing seven instead of six and a half—a temporary over-provision of 8 per cent. If North Glamorgan NHS Trust find themselves in a similar position, they will have to employ two instead of one and a half—an over-provision of 25 per cent—and so on.

6.10. The second factor is more subtle. Almost all DGHs serve an economically mixed population. The better off within it tend to under-use the services, so that the less well-off can get a bigger proportionate share without disturbing the notion of the equity of overall *per capita* funding. The higher the proportion of the less well-off, however, the less effective such a trade-off becomes until, in the limit, as we have argued, when all the catchment population is "less well-off" no such internal trade-off is possible.

6.11. The development of Health Improvement Programmes is a positive step in attempting to redress health inequalities but fails to deal adequately with the problem because it is Health Authority Area based. Where there is a large segment of the relatively affluent amalgamated with the deprived, resources are again diffused instead of being focused. It is imperative, therefore, that the use of per capita funding, adjusted by a suitable weighting factor for need, which is currently used to distribute from the centre to Health Authorities MUST be applied with some rigour to the distribution from Health Authorities to Trusts and other Providers. There is insufficient transparency at present to assess whether this is even attempted in any way. In parenthesis, we suggest that the existing formula is far from representing reality anyway.

7. What Needs Doing

7.1 One solution to the health problems faced by Merthyr, Cynon and Rhymney Valleys would be the adoption in Wales of Health Action Zones, as introduced into England. There can be no doubt that if such zones were introduced, North Glamorgan would be first off the starting blocks as an area of greatest need.

7.2 However, we believe the problems and its solutions are not just parochial and deserve wider attention. We would suggest that:

(i) Welsh Office Ministers should say explicitly what they have already indicated implicitly, namely that planning and funding should not be based on any English notion of ideal DGH size.

(ii) Welsh Office should make it clear to Health Authorities that it wishes to see evidence that their financial allocations to Local Health Groups and to Trusts (whether by contracts or not) have taken realistic cognisance of health inequalities and that they have a reasonable plan to measure their effect in reducing them.

(iii) Welsh Office should develop guidance for Health Authorities on the extent to which funding needs to compensate for the diseconomies of small size. We do not believe that Health Authorities have the expertise to do this and some degree of uniformity throughout the Principality is essential. They should also encourage greater transparency, so that the basis for Health Authority financial allocations is clear to all parties.

8. Conclusions

8.1 More money, though welcome, is not the only answer to the problem of the health inequalities in Wales. Better focused targeting is needed and can be achieved by relatively minor changes in the way central government's policies are translated into local action.

8.2 The transfer of responsibility to the Welsh Assembly is a good opportunity to refine these and make a new beginning.

8.3 The circumstances of these Valley's Health Services provided a unique insight into the failures of past policies and we would welcome a Parliamentary delegation to see the situation at first hand.

Professor MDA Vickers
Chairman

15 March 1999

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9. Memorandum submitted by North Wales Health Authority

SPECIALISED SERVICES AND CROSS BORDER ISSUES

1. Purpose of the Paper

The purpose of this paper is to provide a general briefing on the Authority's current commissioning arrangements for Specialised Services with England and other cross border issues. This is set in the context of current reform changes in the commissioning and financial arrangements affecting Wales.

In particular, the paper covers the following:

— The commissioning of Specialised and Tertiary Services from England.

— Changes in commissioning from a population based approach to a practice based approach and the effect of this between North Wales and England.

— Particular issues with the potential loss of financial and planning controls with the change in process from extra contractual referrals (ECRs) to out of area treatments (OATs).

Attached are details of the funding arrangements for each of the above. Annex.

2. Commissioning of Specialised and Tertiary Referrals From England

Broadly, at 1999–2000 levels and before the proposed changes, the Authority would have expected to contract with England for about £39 million of Specialised, Tertiary and Secondary Services being approximately 10.5 per cent of the North Wales Health Authority's contract portfolio.

All of the Specialised, Tertiary and Acute services purchased for North Wales residents that are not with host District General Hospital Trusts are purchased from English Centres. This is due, to the proximity of the services in Chester, Manchester and Liverpool close to the border; the long distances and relatively poor road links with South Wales; but as importantly, the complex inter-meshing of medical and clinical links involving clinics, staff and technology with English Centres.

There is not yet definitive guidance on what constitutes Specialised Services, and there are a number of grey areas between Secondary and Specialised/Tertiary Services. In addition, a number of contracts with English Trusts will have a mix of both Secondary and Specialised/Tertiary Services. However, of the English contracts of £39 million, the contract with the Countess of Chester is for in excess of £10 million serving parts of the Deeside area with Secondary Services and by most definitions the total for Secondary Services will be at least £15 million.

Contracting separately by the Specialised Health Services Commission for Wales could potentially duplicate a number of contractual arrangements for North Wales patients. It could also blur the objective of seamless commissioning.

North Wales' population is insufficient to provide such services cost effectively within its own borders. The second is that the bulk of the population from Wrexham and the industrial coastal belt around Deeside have a close proximity in distance and social links with Liverpool and Manchester.

3. From Resident to a Practice Based Population

The change from commissioning for a resident based population to commissioning for a practice based population with the setting up of Primary/Local Health Groups has meant that 7,000 (1.1 per cent) of the North Wales population will have services purchased by English Authorities. Conversely North Wales and its Local Health Groups will purchase for 6,600 English patients.

For the first time North Wales will not be responsible for the healthcare of all of its residents.

4. Financial and Planning Controls with the OATS System

In general terms the ECR system is being replaced in 1999–2000 by two mechanisms. The first is to incorporate ECR activity as far as is reasonable to either existing or new long term agreements. The second is to pay for the remainder of the ECRs, which are expected to be the less predictable flows, through the OATs system. In this latter process the Health Authority will pay in retrospect for services consumed by patients. In the first instance for 1999–2000 the Authority is expected to pay for OATs in line with 1997–98 activity repriced to current levels.

The concerns with the process are in two parts. Neither of these are in relation to long term agreements rather both are regarding the OATs process.

— The first is a loss of financial control. The Authority approved all (except emergency) requests for ECRs before treatment. Although bureaucratic, this allowed a management influence on the referral of patients. The Authority encouraged referrals to local services and contracted Specialist Services wherever possible, to promote the development of services within and local to North Wales. It also allowed for proper financial planning and validated controls to be incorporated into the process so that the Authority managed its current spend levels rather than paid at a later date without the ability to influence unplanned referrals and the level of spending.

— The second is that where long term agreements have not been agreed, the default arrangement is seen by some Regions to be the OATs process. There is a fundamental problem with this where a new, planned service has opened in North Wales for its population, funded by former ECR flows to England. If the O.A.Ts process for 1999–2000 is funded on 1997–98 activity levels, planned changes since then will see North Wales having to continue to fund placements (some with significant costs, eg Medium Secure Unit places) that no longer exist having been reprovided locally. This would jeopardise the full opening of new services locally.

Nigel Morris
Director of Finance

19 March 1999

Annex

COMMISSIONING OF SPECIALISED AND TERTIARY REFERRALS FROM ENGLAND

North Wales HA residents are referred to English providers in greater numbers than other Welsh HAs due to the need for a critical mass of patients to sustain such services and the ease of communication to the centres, mainly in Liverpool and Manchester.

Due to the importance of the services, and the size of the expenditure, the need to control funding but also to work strategically with English Trusts, HAs and regions is greater than elsewhere in Wales.

In response to the OATs process described above the HA has elected to expand the number of contracts it has with English providers.

The table shows the approximate values of each of the current and future contracts which the HA is currently negotiating.

	Service Description (if specialised)	*Existing Tertiary Contract*	*Other Contracts*	*New Contracts approx value*
Addenbrookes				54,767
Alder Hay	Paediatrics	3,296,100		
Aintree		227,115		
Bethlem & Maudsley	Mental Health			16,076
Birmingham Childrens	Paediatrics			77,287
BPAS			300,000	
Calderstones	Mental Health			164,122
Cardiothoracic Centre	Cardiac	3,725,450		
Central Manchester	Cardiac	1,847,770		
Countess of Chester			9,481,199	
Chester & Halton				80,228
Christie	Oncology & R/T	789,846		
Clatterbridge	Oncology & R/T	2,175,192		
Glenfield	ECMO			87,220
Gobowen			3,538,953	
Great Ormond Street Hospital	Paediatrics	77,602		
Guild Community				65,590
Guys' & St. Thomas'	Various			26,516
Hammersmith	Various			40,915
Kings' Healthcare	Various			45,196
Liverpool Womens		381,465		
Mid Cheshire			92,520	
Moorfields Eye	Ophthalmology			18,769
Northgate & Prudhoe	Mental Health			459,120
N Manchester				37,298
N Staffs				157,229
Northwick Park	Intestinal Failure			58,885
N Warwickshire	Mental Health			84,730
Royal Liverpool	Various	2,222,587		
Royal Marsden	Oncology & R/T			39,832
Royal National Orthopaedic	Orthopaedic			77,474
Royal Orthopaedic	Orthopaedic	59,366		
R Shrewsbury			122,024	
Salford Royal	Intestinal Failure			124,930
Shrop Com/MH		43,667	43,667	
S Manchester	incl Cystic Fibrosis	402,403		
Southport	Spinal	290,230		
S Tees Community				90,155
St. James University	Various			39,037
St. Mary's	Various			56,188
United Leeds	Various			15,776
UCLH	Various	50,401		
UHB (QE)	Liver Medicine	102,985		
Walton	Neurosciences	3,148,000		
Whiston	Burns	630,643		
W & W Cheshire			1,036,936	
Wirral	Head Injury rehab	425,156		
Wrightington				72,836
Totals		**19,895,978**	**14,615,299**	**1,990,176**

Note:

1. The above do not usually include the four current GPFHs.

2. The above does not include changes for cross border flows due to the change to practice based commissioning.

3. The new contracts figures are the OATs figure, to be replaced by the negotiated contract prices as these are agreed.

4. The above excludes the all-Wales Heart & Lung Transplants contracts and any other centrally funded (NSCAG) services.

CROSS BORDER FLOWS

Due to the White Paper's requirement that HAs commission services for the practice based populations, instead of the residents of the area, each HA and Trust has had to examine the effect on current contracts and to agree changes with other HAs.

The following summarises the latest report issued to WO and neighbouring HAs.

	Inflow(£)	*Outflow(£)*	*Net Transfers(£)*
Shropshire	1,453,827.00	189,721.00	−1,264,106.00
South Cheshire	344,640.00	1,572,599.00	1,227,959.00
Totals	1,798,467.00	1,762,320.00	−36,147.00

OUT OF AREA TREATMENT (OATS)—1999–2000 FUNDING

— Each UK Trust and Health Authority has agreed patient activity, and the value of that activity, for the year 1997–98.

— The following are the figures for N Wales HA and the current Trusts located in N Wales.

— N Wales HA will be top-sliced the amounts shown—which will be passed in identified amounts to Trusts from their local HA, within each region.

— The system assumes that this funding then covers the cost of treating any patient from outside the area, unless a separate agreement (contract) has been reached with the relevant HA.

— N Wales has agreed most of the figures, but faces a serious problem relating to the development of the N Wales Medium Secure Unit.

The problem is that in 1997–98 N Wales residents used two MSUs but all the patients have now been discharged.

There is no likelihood of any using the same services now that the N Wales unit is open. The funding which the Trusts in W Midlands are expecting is required to fund the unit in N Wales. If funding "follows the patient" with a delay of up to two years then there may be a planning blight for some developments.

(a) N Wales HA.		*(£)*
North & Yorkshire		100,162
Trent		136,739
Anglia & Oxford		92,413
N Thames		267,820
S Thames		72,578
South & West		195,147
W Midlands		631,189
North West		277,309
Sub Total	England	1,773,357
	Scotland	203,154
	Wales	121,371
	Total	**2,097,882**

(b) N Wales Trusts	*(£)*
Clwydian	78,357
Glan Clwyd	901,577
Gwynedd Community	214,355
Gwynedd Hospitals	1,211,825
Wrexham	379,979
Total	**2,786,093**

10. Letter submitted by the Society of Cardiothoracic Surgeons of Great Britain and Ireland

Thank you for asking me to comment on the minutes of evidence taken before the Welsh Affairs committee on Tuesday 23 March 1999. I apologise for the delay in replying. Unfortunately much of my "spare" time has been taken up with reading the transcript of the Bristol Inquiry, much of which is relevant to the re-opening of the paediatric cardiac surgical unit in Cardiff.

I thought that the statement made by Dr Kirk was very fair, knowledgeable and accurate.

There are certain facts which are immutable. The first is that the workload for paediatric cardiac surgery at Cardiff is approximately 70 cases per annum and this is unlikely to rise dramatically. This volume of work is insufficient for two paediatric cardiac surgeons. The second fact is that these days it is considered unacceptable to have a single handed cardiac surgeon working in isolation. Therefore Professor de Leval suggested that a paediatric cardiac surgeon appointed in Cardiff should be linked to, and in effect functionally be part of, another larger unit. He has suggested Bristol because of its proximity to Cardiff and this seems eminently sensible.

Question 114 of the oral evidence states "Bristol's reputation is under a cloud to put it mildly". This is not true. The results in Bristol these days are excellent and widely available for anybody to view. I assume that Ms Morgan's comments in question 117 were made somewhat tongue in cheek. One can appreciate that a totally dedicated surgeon working single handedly might strive to produce the best results. Conversely his work could progressively decline in quality until the results were markedly substandard. The Society of Cardiothoracic Surgeons does not support the appointment of a single handed surgeon working in isolation.

J E Dussek FRCS

20 May 1999

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11. Letter submitted by the Royal College of Surgeons of England

Having now had the opportunity to consider the matter, the President has asked me to respond on the following lines.

The College considers the comments of Dr Richard Kirk to be thoughtful and well balanced.

The College does not support the provision of a service by a single-handed cardiac surgeon on the grounds of lack of cover for holidays, illness and other absences and the possibility of progressive deterioration of standards resulting from unsustainable demands. Having said this, the College acknowledges the high standard of the work being done by Mr Musumeci.

The College supports Professor Marc de Leval's recommendation that a link is the way forward and agrees that a link with Bristol would be more appropriate in terms of geographical factors taking into account the high standards of care that are now unquestionably being delivered there. A link with Birmingham is an alternative suggestion but there is concern that this could be difficult to maintain effectively given practical problems that can arise with the factor of distance.

Craig Duncan
College Secretary

21 May 1999

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12. Supplementary memorandum submitted by Dr Richard Kirk, Welsh Congenital Heart Disease Centre

I enclose an addendum to my original briefing paper to appraise the Welsh Affairs Committee of the current situation on Paediatric Cardiac Services.

I believe that a combination of Options D and G will represent the best approach to excellent and cost effective care for patients and enclose details of the proposed service utilising these options.

University Hospital of Wales

26 May 1999

Annex

CURRENT SITUATION ON PAEDIATRIC CARDIAC SERVICES

The provision of care is dependent upon whether a surgical service is re-established and whether a cardiology service is based in South Wales. An appraisal of these options is presented below.

The South Wales Surgical Service

The changes occuring in the UK provision of care and new working hours regulations has meant that the Congenital Heart Disease Centre must undergo a major re-structuring process. Central to this process is a consideration of the surgical service.

There are four surgical options with continuance of local cardiology:

A. *Single Surgeon Centre*

The Royal College of Surgeons' report stated that this was not a viable option unless the Cardiff and Bristol Units merged as a single unit providing cardiology and surgery on two sites. Negotiations with Bristol have concluded that whilst Bristol would like to collaborate medically they do not feel able to undertake the surgical collaboration necessary to meet the Royal College of Surgeons' requirements for continuance of cardiac surgery in Wales.

B. *Double Surgical Centre*

This model was put to the Royal College of Surgeons but was not given serious consideration as it was their view that the workload was too small for two surgeons and the College was not persuaded that this would be mitigated by both surgeons working together. This is also the view of the Society of Cardiothoracic Surgeons of Great Britain and Ireland.

C. *Surgical Provision from Another Centre*

As the closest geographical centre the logical choice would be Bristol. Their surgical services have improved over recent years and they have recently made an additional surgical appointment. Currently however they do not undertake the whole range of surgical interventions. Additionally due to the current adverse publicity there is reluctance amongst Welsh patients and families to be treated in the Bristol Unit.

D. *Surgical Provision from Several Centres*

No one Centre is equally expert in every type of procedure, nor are they constantly expert in a procedure over a long period of time. Utilising the strengths of many Centres would allow treatment of children in the Centre most expert in their particular disease and allow increased patient choice. It would require careful management to ensure the quality of the surgical service provided.

Options A and B are now no longer viable given the Bristol Children's Cardiac Unit's decision to decline to collaborate surgically and the views of the Royal College of Surgeons and the Society of Cadiothoracic Surgeons.

South Wales Cardiology Service

It is important to decide if a locally based cardiology service for South Wales is necessary in the absence of a surgical service and if so what form it should take. Undoubtedly future cardiac care in the Principality should be excellent, minimise out of Wales referrals, ensure that when a patient requires an intervention it is undertaken in a Centre with the best outcome for their disease, provide support for paediatricians, obstretricians and cardiologists, training for junior staff in Wales and carefully audit outcomes.

Currently the cardiology service provides for the fetus, child and adult with congenital cardiac disease, training for undergraduate and postgraduate staff and audit of activity. It also has a significant input into the provision of intensive care and children with multisystem problems who often require cardiac assessment.

In all three options (outlined below) either Surgical Option C or D may be chosen. In either model the Welsh cardiologist would discuss patients requiring surgery directly with the surgeon enabling robust clinical decisions to be made and continued professional development. Provision of a regional paediatric intensive care and transportation service will also be necessary.

E. *No Locally Based Service*

All cardiology and surgical services would be provided on an outreach basis by another Centre(s) with a surgical unit eg Bristol. This was the type of service South Wales received prior to the Congenital Heart Disease Centre opening in 1991. Whilst this model could provide a basic service for the Principality it is unlikely to provide the comprehensive service outlined above.

F. *"Manchester" Style Service*

This is the service provided since cessation of surgery to the majority of paediatricians. The service requires a dedicated inpatient unit in Cardiff undertaking all emergency and elective cardiology assessments. For such a service to be sustainable it requires the full support of all paediatricians in South Wales but even given that there are grave reservations that the inpatient activity levels would be sufficient either to maintain staff skills or be cost effective.

G. *Locally Based Supportive Cardiology Service*

Independent paediatric cardiologists would continue to provide specialist advice. No dedicated inpatient facilities would be required but access to inpatient beds would be necessary for some elective procedures. Additional outreach clinics would provide increased support and advice to paediatricians, obstetricians and adult cardiologists. Tele-medicine links would aid the assessment of patients.

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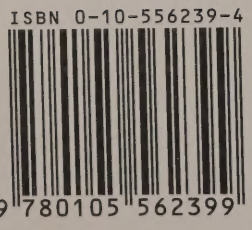

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